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No. _____

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In The

Supreme Court of the United States

October Term, 1993

UNITED WIRE, METAL & MACHINE HEALTH AND WELFARE FUND; TRUSTEES OF THE OPERATING ENGINEERS LOCAL 825 WELFARE FUND; TEAMSTERS LOCAL 11 BENEFIT PLAN; TRUSTEES OF THE TEAMSTERS LOCAL 11 BENEFIT PLAN; LOCAL 807 LABOR-MANAGEMENT HEALTH FUND; THE TRUSTEES OF THE LOCAL 807 LABOR-MANAGEMENT HEALTH FUND; LOCAL 464A UNITED FOOD AND COMMERCIAL WORKERS UNION GROUP REIMBURSEMENT WELFARE FUND; and LOCAL 945 IBT WELFARE FUND,

Petitioners,

v.

MORRISTOWN MEMORIAL HOSPITAL; FRANCES J. DUNSTON, in his capacity as New Jersey Commissioner of Health; et al.,

Respondents.

Petition For A Writ Of Certiorari To The United States Court Of Appeals For The Third Circuit

PETITION FOR A WRIT OF CERTIORARI

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QUESTIONS PRESENTED FOR REVIEW

1. Is health care regulation by a state exempt from the Employee Retirement Income Security Act's ("ERISA") preemption clause based upon a "traditional state police power," as the Third Circuit Court of Appeals concludes, or should Congress' mandate and this Court's precedent regarding the broad scope of ERISA's preemption be reaffirmed?

2. Did the Third Circuit Court of Appeals ignore this Court's ERISA preemption standard when it determined that a health care statute did not "relate to" ERISA even though the statute shifted a disproportionate share of the cost of hospital care for the indigent onto ERISA participants who, comprising only 15% of the hospital users, were forced to pay for 40% of the uncompensated care costs in New Jersey?

PARTIES TO THE PROCEEDINGS

All parties to this proceeding appear in the caption of the Third Circuit Court of Appeals Decision which is contained in the Appendix at 1a-5a. Because of the numerosity of the parties, the list will not be reproduced herein.

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Petitioners United Wire, Metal & Machine Health and Welfare Fund, the Operating Engineers Local 825 Welfare Fund, Teamsters Local 11 Benefit Plan, Trustees of the Teamsters Local 11 Benefit Plan, Local 807 Labor-Management Health Fund; The Trustees of the Local 807 Labor-Management Health Fund; The Trustees of the

Local 807 Labor-Management Health Fund, Local 464A United Food and Commercial Workers Union Group Reimbursement Welfare Fund, and Local 945 IBT Welfare Fund (the "Welfare Funds") respectfully petition for a writ of certiorari to review the judgment of the United State Court of Appeals for the Third Circuit entered on May 14, 1993.

OPINIONS BELOW

The Order of the Court of Appeals for the Third Circuit, for which review is sought, is unofficially reported at 61 U.S.L.W. 2723 (3d Cir. May 14, 1993) and is reprinted in the Appendix.[1] (1a) The decision of the United State District Court for the District of New Jersey is reported at 793 F. Supp. 524 (D.N.J. 1992) and is reproduced for the Court's convenience in the appendix. (64a). Additionally, the unreported order of the Court of Appeals denying a rehearing is contained in the appendix. (62a)

[1] The Welfare Funds respectfully rely upon the Appendix already submitted by petitioner NYSA-ILA Welfare Fund under Docket No. 93-115, which was filed with the Supreme Court on July 22, 1993. All cites to the Appendix in this petition for Certiorari shall refer to this Appendix and shall hereinafter be abbreviated (___a).

JURISDICTION

Judgment was entered by the Court of Appeals for the Third Circuit on May 14, 1993. On July 8, 1993, the Court of Appeals granted Petitioner's Motion for Stay of Mandate, which stay was extended until August 6, 1993 by further Order dated July 16, 1993. This Court has jurisdiction pursuant to 28 U.S.C. 1254(1).

CONSTITUTIONAL PROVISIONS AND STATUTES INVOLVED

1. The Supremacy Clause of the United States Constitution, U.S. Const., Art. VI. cl. 2., provides in relevant part:

> "This Constitution, and the Laws of the United States which shall be made in pursuance thereof . . . shall be the supreme Law of the Land . . . , any Thing in the Constitution of Laws of any State to the Contrary notwithstanding."

2. The relevant statutory provisions of ERISA are as follows:

(a) ERISA's preemption clause is contained in Section 514(a), 29 U.S.C. § 1144(a) which provides:

> except as provided in subsection (b) of this section, [ERISA] shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in Section 4(a) and not exempt under Section 4(b).

(b) ERISA, 29 U.S.C. § 1103(c)(1):

> the assets of a plan . . . shall be held for the exclusive purpose of providing benefits to participants in the plan and their beneficiaries . . .

STATEMENT OF THE CASE

This is a petition for certiorari to review a judgment of the United States Court of Appeals for the Third Circuit. As described below, this action involves a challenge under ERISA's preemption provision to three surcharges levied on hospital users pursuant to the New Jersey hospital rate setting scheme. These surcharges are designed to disproportionately syphon money from ERISA welfare funds to pay for a state mandated social program to subsidize the cost of health care for the indigent. On petitioners' motion for summary judgment in the District Court the rate setting scheme was declared preempted by ERISA.[2] This ruling was reversed on appeal by the Third Circuit Court of Appeals by a 2-1 majority.

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[2] On January 1, 1993, the hospital billing scheme in New Jersey was replaced with a new system. Although the specific billing scheme as challenged has been abandoned, the questions presented on this petition remain significant and, as the Third Circuit recognized, certainly are not moot. In addition to large monetary claims between the Welfare Funds and hospitals in this action, the decision has wide-spread implications on the structure of hospital billing schemes nationwide. Several other states have existing health care systems, similar to that challenged herein. Consequently, this Court's consideration of the present petition will determine whether hospital rate regulation can continue to be structured nationwide to extract from ERISA funds a disproportionate share of our country's health care bill.

The Challenged Rate Setting Scheme

The New Jersey hospital rate setting scheme was established pursuant to the New Jersey Health Care Facilities Planning Act (the "Planning Act"), as amended and supplemented by the Health Care Cost Reduction Act (the "Reduction Act"), N.J.S.A. 26:2H-1 *et seq.* (collectively, the "Act"), as well as the regulations promulgated thereunder, N.J.A.C. 8:31B *et seq.* Pursuant to the rate setting scheme, patients in New Jersey receive hospital bills based upon a categorization into Diagnostic Related Groups ("DRG"). The DRG billing rate is selected by the hospital based upon a clinical categorization of a patient's illness and treatment into one of 742 categories of medical conditions. In accordance with procedures and rates established by the State, each DRG category is assigned a hospital specific dollar amount, based upon the specific hospital's costs as well as statewide averages, which the hospital is required to charge regardless of whether the actual medical costs incurred in treatment of the patient are above or below the DRG rate. The DRG base cost encompasses a wide variety of direct and indirect patient costs, including employee salaries, and institutional overhead expenses for management, educational, research and maintenance functions.

Although originally intended as such, the DRG charge is no longer simply a weighted average of expected medical costs for a given condition. The weighted average component is merely the base cost upon which surcharges are added to arrive at the actual DRG rate charged to a patient. Surcharges or "add-ons" are included in the DRG rate as follows: (1) a 19.1% surcharge to pay for uncompensated care to the indigent

and poor; (2) a 7% surcharge to compensate hospitals for a shortfall provided by the federal Medicare program; and (3) a maximum 11% payor differential added to counter-balance the discounts granted to certain classes of payors, such as Blue Cross. Each of these surcharges is designed to raise funds to pay for care for the poor. The Welfare Funds do not challenge the base DRG system, but rather the specific surcharges included therein.

The Uncompensated Care Surcharge

Hospitals in New Jersey are prohibited by state statute from denying admission to patients on the basis of their ability to pay and are required to treat every patient who seeks treatment. To compensate hospitals for their required treatment of the indigent and uninsured, referred to as "uncompensated care", a 19.1% surcharge is added to the DRG base cost on each patient's bill. This uncompensated care add-on is collected by each hospital and forwarded to the New Jersey Health Care Trust Fund, which fund then redistributes the money to hospitals state-wide based upon the amount of uncompensated care costs incurred by each individual hospital.[3]

The Medicare Cost Shift

In addition to the uncompensated care add-on, each hospital bill includes a 7% add-on to compensate

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[3] These funds are also used by the State to obtain matching federal funds, which, rather than being used to offset health care, are placed into the State's general treasury to pay for other expenses of government.

hospitals for the "Medicare cost shift." Under the federal Medicare program, hospitals are reimbursed by the federal government for services provided to Medicare patients. However, pursuant to the administration of the Medicare program, New Jersey hospitals are reimbursed for the care provided at a lower rate than the New Jersey DRG rate. Thus, included in the DRG rate is a "Medicare cost shift" that forces other hospital payors to underwrite the shortfall between the DRG rate and the rate of reimbursement from Medicare.

The Payor Differentials

The third cost-shifting mechanism under the DRG rate system involves "payor differentials", or discounts in payment rates available to certain favored classes of payors. These discounts are offered to select payors who demonstrate "quantifiable economic benefit" to the health care system, such as Blue Cross, Blue Shield and health maintenance organizations. For example, Blue Cross receives an 11% discount because of its open enrollment policy. Due to restrictions imposed by ERISA, the Welfare Funds must limit their enrollment and cannot receive this same discount, even though the ERISA plans provide open enrollment within the category of workers and their families eligible to participate in their plans. Discounts have been granted to all classes of payors except commercial insurers and self-funded payors such as the Welfare Funds. As a result of the discounts offered to certain payors, a surcharge is levied on the remaining payors to offset revenue losses generated by the payor discounts. Thus, the Welfare Funds must pay higher fees in order to make up for the discounts offered to others.

The Impact Of the Hospital Billing Scheme on ERISA Plans

These surcharges were implemented by the State in an effort to pay for the growing cost of uncompensated medical care, which costs have increased from a level of $288 million in 1983 to in excess of $700 million dollars in 1990. In New Jersey alone, ERISA participants who comprise 15% of the hospital patients each year are required to pay 40% of the current $1.1 billion dollars of state-mandated cost shifts. This $450 million dollar charge against ERISA funds and their participants reflects one year's burden alone. These surcharges, characterized in the Report of the Governor's Commission on Health Care Costs as a tax to subsidize a social program, increase the average hospital bill charged to ERISA plan participants in New Jersey by approximately 37%. As noted by Judge Nygaard in his dissenting opinion, these surcharges are specifically designed by the State to syphon ERISA plan funds to subsidize non-ERISA fund hospital patients.

The District Court's Decision

Plaintiff/Petitioner United Wire filed its complaint on July 3, 1990. Several other welfare funds then filed similar complaints which were all consolidated. Defendant, the State of New Jersey (the "State"), and intervenor defendant, the New Jersey Hospital Association (the "Hospital Association") moved to dismiss the complaints under Fed. R. Civ. P. 12(c); the Welfare Funds cross-moved for summary judgment.

By Order dated May 27, 1992, and clarified by Order dated June 4, 1992, the District Court granted summary judgment to the Welfare Funds and granted permanent injunctive relief barring the prospective enforcement of the challenged statutory and regulatory provisions. In its opinion the District Court found several bases for ERISA preemption under the "relate to" test established by the Supreme Court, holding that the statutes and regulations had both direct "references to" ERISA plans and had a "connection with" such plans. The Court specifically found that the hospital billing scheme forced the Welfare Funds to structure their benefits in a particular manner; interfered with the Welfare Funds purpose by preventing them from providing full coverage of hospital bills; subjected the funds to inconsistent state regulation; interfered with the administration of fund benefits; forced the funds to incur substantial costs for the benefit of non-members in direct violation of ERISA; interfered with the relations among the principal ERISA entities; interfered with the calculation of plan benefits; and interfered with a participant's right to appeal a bill by mere virtue of his membership in the plan. The District Court declined to exercise jurisdiction over the Welfare Funds' claims for reimbursement of hospital bills paid under protest, saying that these common law claims belonged in State court.

The Third Circuit's Decision

The State Hospital Association and various individual defendant hospitals filed notices of appeal. The Welfare Funds cross-appealed challenging the District Court's refusal to exercise jurisdiction over the

claims for reimbursement of hospital bills paid under protest during the pendency of the lawsuit.

In a 2-1 split decision, the United States Court of Appeals for the Third Circuit reversed the District Court's decision and entered judgment in favor of respondents. The majority relied upon a purported exemption to ERISA preemption for state statutes dealing with "traditional state police powers" and concluded that, despite the substantial economic impact the scheme had on ERISA plans and despite the enormous diversion of plan resources from the intended ERISA beneficiaries, the statute had only a "tenuous, remote or peripheral" effect on the Welfare Funds. Having reversed the District Court, the Third Circuit never addressed the Welfare Funds' claims for reimbursement of bills paid under protest during the litigation. If the Supreme Court grants this petition and reverses the Third Circuit, it should remand the reimbursement issue for further consideration.

A WRIT OF CERTIORARI SHOULD ISSUE BECAUSE THE THIRD CIRCUIT'S DECISION CONFLICTS WITH ERISA'S BROAD PREEMPTION CLAUSE AND WITH THE SUPREME COURT'S PREEMPTION STANDARD

I. The Expansive Scope of ERISA's Preemption Clause

The Supremacy Clause of the United States Constitution provides that "the Laws of the United States shall be the supreme Law of the Land." U.S. Const., Art. VI. cl. 2. Under the preemption doctrine attendant to the Supremacy Clause, a state law must give way to

Congressionally enacted statutes where the state law "stands as an obstacle to the accomplishment and execution of the full purposes and objectives of Congress." *Hines v. Davidowitz*, 312 U.S. 52, 67 (1941); *U.S.A. Chamber of Commerce v. State*, 89 N.J. 131, 142 (1982). "Preemption may be either express or implied, and is compelled whether Congress' command is explicitly stated in the statute's language or implicitly contained in its structure and purpose." *FMC Corp. v. Holliday*, 498 U.S. 52, 56-57 (1990); *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 95 (1983); *Fidelity Fed. S & L Ass'n v. De La Cuesta*, 458 U.S. 141, 152-53 (1982); *Jones v. Rath Packing Co.*, 430 U.S. 519, 525, *reh. denied*, 431 U.S. 925 (1977).

ERISA is a comprehensive statute designed to promote the interests of employees and their beneficiaries in employee benefit plans. *Shaw*, 463 U.S. at 90. To this end, ERISA contains a broad preemption provision in Section 514(a), 29 U.S.C. § 1144(a) that provides:

> except as provided in subsection (b) of this section, [ERISA] shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in Section 4(a) and not exempt under Section 4(b).

29 U.S.C. § 1144(a).

The United States Supreme Court has determined consistently that Congress expressly provided a "broadly worded preemption provision in a comprehensive statute," *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 138 (1990) which "is conspicuous for its breadth," *FMC Corp.*, 498 U.S. at 58. As discussed by the Supreme Court, the legislative history supports an expansive construction of

ERISA's preemptive effect. *Shaw*, 463 U.S. at 98-99, n.20; *FMC Corp.*, 498 U.S. at 58-59.

The key to interpreting the breadth of ERISA's preemption clause are the words "relate to."

> Congress used those words in their broad sense, rejecting more limited preemption language that would have made the clause 'applicable only to state laws relating to the specific subjects covered by ERISA.'

Ingersoll-Rand, 498 U.S. at 138 (quoting *Shaw, supra*, at 98).[4] With regard to this broad intent, the Supreme Court has defined the phrase "relate to" in the context of the ERISA's preemption clause by stating:

> A law *relates to* an employee benefit plan . . . if it has a connection with or reference to such a plan.

Shaw, 463 U.S. at 96-97.

> Under this "broad common sense meaning," a state law may "relate to" a benefit plan, and thereby be preempted, *even if the law is not specifically designated to affect such plans, or the effect is only indirect.*

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[4] To further enhance the preemption clause's broad scope, the terms "State law" and "State" were broadly defined. With respect to ERISA's preemption clause, the term "State law" includes "all laws, decisions, rules, regulations or other State action having the effect of law, of any State." ERISA Section 514(c)(1), 29 U.S.C. § 1144(c)(1). The term "State" includes "a State . . . or any agency or instrumentality . . . which purports to regulate, *directly or indirectly, the terms and conditions* of employee benefit plans covered by this title." ERISA Section 514 (c)(2), 29 U.S.C. § 1144(c)(2) (emphasis supplied).

Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41, 47 (1987) (emphasis added). See *Ingersoll-Rand*, 498 U.S. at 138-139; *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 525 (1981); *Shaw*, 463 U.S. at 98. ERISA's preemption clause distinctly applies to state laws dealing with matters not themselves covered under the ERISA statute, *FMC Corp.*, 498 U.S. at 58-59; *Ingersoll-Rand*, 498 U.S. at 138, and even if the state law is "consistent with ERISA's substantive requirements," *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724 (1985), or if the law was enacted to "effectuate ERISA's underlying intent." *Mackey v. Lanier Collection Agency & Service, Inc.*, 486 U.S. 825 (1988).

In its two most recent decisions addressing preemption under ERISA, the Supreme Court again reiterated its broad and expansive reading of ERISA's preemption clause. In *FMC Corp. v. Holliday*, 498 U.S. 52 (1990), a self-funded health care plan, after paying a portion of the participant's medical expenses stemming from an automobile accident, attempted to recover its expenses pursuant to a subrogation clause contained in its plan from a participant who had recovered damages in a negligence action relating to the accident. Pennsylvania's statutory law contained a provision prohibiting recovery by any program, group contract or other arrangement upon any subrogation rights. Under the "relate to" test, the Supreme Court struck down the Pennsylvania law on preemption grounds because the law had a specific "reference to" ERISA plans contained in its language and additionally a "connection with" such plans. In evaluating the laws "connection with" the benefit plan the Supreme Court stated:

> Pennsylvania's antisubrogation law prohibits plans from being structured in a manner

> requiring reimbursement in the event of recovery from a third party. It requires plan providers to calculate benefit levels in Pennsylvania based on expected liability conditions that differ[ed] from those in states that [had] not enacted similar antisubrogation legislation. Application of differing state subrogation laws to plans would therefore frustrate plan administrators' continuing obligation to calculate uniform benefit levels nationwide.

FMC Corp., 498 U.S. at 60.

In *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133 (1990), the Supreme Court addressed whether ERISA's explicit language and purpose preempted a state common law cause of action by an employee who was wrongfully discharged to prevent his attainment of benefits under an ERISA covered plan. In striking down such a cause of action, the Court noted:

> Section 514(a) was intended to ensure that plans and plan sponsors would be subject to a uniform body of benefit law; the goal was to minimize the administrative and financial burden of complying with conflicting directives among States or between States and the Federal Government. Otherwise, the inefficiencies created could work to the detriment of plan beneficiaries. Allowing state based actions like the one at issue here would subject plans and plan sponsors to burdens not unlike those that Congress sought to foreclose . . . . Particularly disruptive is the potential for conflict in substantive law. It is foreseeable that state courts, exercising their common law powers, might develop different substantive standards

> applicable to the same employer conduct, requiring the tailoring of plans and employer conduct to the peculiarities of the law of each jurisdiction. Such an outcome is fundamentally at odds with the goal of uniformity that Congress sought to implement. (Citations omitted).

Id. at 141. *See also Shaw*, 463 U.S. at 105 and n. 25.[5] Thus, it is overwhelmingly clear that ERISA was designed to establish the regulation and administration of ERISA benefit funds as *exclusively* a federal concern.

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[5] In addition to the Supreme Court's reiteration of a vastly broad ERISA preemption test, numerous cases have expounded upon the expansive nature or this preemptive clause. In analyzing whether a statute has a "connection with" ERISA benefits plans, Courts will seek to ensure that substantive benefits not be subject to the ambiguities of state law. *PPG Indus. Pension Plan A (CIO) v. Crews*, 902 F.2d 1148, 1151 (4th Cir. 1990). ERISA forbids a result whereby a subject plan will apply differently to otherwise identically situated beneficiaries who live in different states under different statutory regimes. *Id. See also Local Union 598 v. J.A. Jones Const. Co.*, 846 F.2d 1213, 1219 (9th Cir. 1988). Also forbidden are attempts to prescribe either the type or amount of an employer's contribution; the rules and regulations under which a plan operates; or the nature or amount of the benefits provided thereunder. *General Electric v. Dept. of Labor*, 891 F.2d 25, 29 (2d Cir. 1989), *cert. denied*, 496 U.S. 912 (1990) (amount of contribution); *Local Union 598*, 846 F.2d at 1219 (amount of contribution); *Stone v. Webster Eng'g Corp.*, 690 F.2d 323, 329 (2d Cir. 1982), *aff'd sum. sub nom, Arcudi v. Stone and Webster Eng'g Corp.*, 463 U.S. 1220 (1983) (amount of contribution); *Hewlett-Packard Co. v. Barnes*, 425 F. Supp. 1294, 1297-1300 (N.D. Cal. 1977), *aff'd*, 571 F.2d 502 (9th Cir.) (*per curiam*), *cert. denied*, 439 U.S. 831 (1978) (rules under which plan operates); *Standard Oil Co. v. Agsalud*, 442 F. Supp. 695, 706-07 (N.D. Cal. 1977), *aff'd*, 633 F.2d 760 (9th Cir. 1980), *aff'd sum.*, 454 U.S. 801 (1981) (nature or amount of benefits).

II. ERISA's Preemption Clause Applies To State Health Care Regulation

The expansive scope of ERISA preemption applies to state health care regulation. Time after time the courts have had to curtail state health care regulations that have infringed upon ERISA welfare funds. A solid line of precedent exists, particularly when states have sought to extract money from ERISA funds to pay for social programs. *See The Travelers Ins. Co. v. Cuomo*, 813 F. Supp. 996 (S.D.N.Y. 1993), *appeal pending*, Docket No. 93-7132 (2d Cir. 1993) (surcharges applied to hospital bills were preempted because of the substantial economic impact the surcharges had on ERISA plans and the diversion of plan resources from the intended ERISA beneficiaries); *Bricklayers Local No. 1 Welfare Fund v. Louisiana Health Ins. Assoc.*, 771 F. Supp. 771 (E.D. La. 1991) (two dollar surcharge on hospital bills to fund the administration of a catastrophic health insurance program was preempted by ERISA); *United Health Services, Inc. v. Upstate Administrative Services*, 573 N.Y.S.2d 851, 14 E.B.C. 1301 (N.Y.S. Sup. Broome Cty. 1991) (invalidating aspects of New York State DRG system); *E-Systems, Inc. v. Pogue*, 929 F.2d 1100 (5th Cir.), *cert. denied*, 112 S. Ct. 585 (1991) (finding tax on benefits received to be preempted).[6]

These cases illustrate that ERISA welfare funds cannot be unduly burdened, either economically or

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[6] Additionally, in 1982, Congress amended ERISA's preemption provision to exempt the Hawaii Prepaid Health Care Act. 29 U.S.C. § 1144(b)(5)(B)(i). This limited amendment shows that the scope of ERISA preemption was intended to affect health care funding.

administratively, by particular state attempts at health care regulation. A state may regulate health care, but it may not force ERISA funds to jeopardize their well-being by supporting programs for those who have not contributed to the ERISA fund. Petitioners' challenge in this action follows this simple, straightforward rationale, which compels a conclusion that the New Jersey hospital scheme is likewise preempted.

For reasons unknown, the Third Circuit chose to ignore the solid precedent that should have led to the preemption of the hospital surcharges against the Welfare Funds. The Court speculated that Congress did not intend ERISA preemption to extend to the regulation of health care costs. As stated by the majority:

> In short, we are unwilling to attribute to Congress and [ERISA's preemption clause] an intent to frustrate the efforts of a state, under its police power, to regulate health care costs. In particular, we are unwilling to infer from ERISA's prohibition against applying fund assets for the benefit of others a Congressional intent to foreclose health care cost regulation of the kind here challenged.

(31a-32a).

Faced with no support from Congress for its position and a wave of cases against it, the majority resorted to the single 1984 case of *Rebaldo v. Cuomo*, 749 F.2d 133 (2d Cir. 1984), *cert. denied*, 472 U.S. 1008 (1985), which upheld a New York statute prohibiting ERISA funds from negotiating discount rates with hospitals. The *Rebaldo* decision, which predates many of the Supreme Court's recent ERISA preemption cases, relies upon a purported

preemption exception for state laws dealing with areas of "traditional state police power." As discussed below, the *Rebaldo* decision is not in accord with the current state of the law.

The underlying rationale of *Rebaldo* has been expressly overruled. As acknowledged by the majority, *Rebaldo* used a narrow formulation of the "relate to" clause in ERISA – holding preemption occurred only where the statute directly "affect[ed] the structure, administration, or the type of benefits provided by an ERISA plan." *Id.* at 139. (28a-30a) This restrictive approach to ERISA preemption was expressly overruled in *Ingersoll-Rand*, 498 U.S. at 141-142. *See also General Motors Corp. v. Caldwell*, 647 F. Supp. 585, 588 (N.D.Ga. 1986); *United Health Services*, 573 N.Y.S. 2d at 854-855.

In addition, *Rebaldo*'s holding that health care regulation is exempted from ERISA's preemption clause as a "traditional state police power" has been expressly rejected in subsequent preemption decisions. As recently explained in *Arkansas Blue Cross and Blue Shield v. St. Mary's Hospital, Inc.*, 947 F.2d 1341, 1350 (8th Cir. 1991), *cert. denied*, 112 S. Ct. 2305 (1992):

> We reject St. Mary's argument that preemption is not appropriate because the assignment statute is an exercise of traditional state power. Like the Fifth Circuit we are "not convinced that . . . the traditional or nontraditional nature of the state law . . . properly bears upon the question whether a state law of general application affects a benefit plan in so tenuous, remote, or peripheral a way that it cannot be said to 'relate to' the plan." Although the Supreme Court has not discussed the relevance

> of this factor, its failure to consider this criterion when deciding ERISA preemption cases is telling. *See FMC Corp v. Holliday*, ___ U.S. ___, 111 S. Ct. 403, 112 L.Ed.2d 356 (1990); *Mackey v. Lanier Collections Agency & Serv.*, 486 U.S. 825 (1988) (state garnishment law).

This "traditional state power" rationale has never been utilized as a relevant factor by the Supreme Court and has been rejected or ignored in several recent ERISA preemption challenges expressly dealing with surcharges imposed upon hospital bills. *See The Travelers Ins. Co. v. Cuomo*, 813 F. Supp. 996 (S.D.N.Y. 1993), appeal pending, Docket No. 93-7132 (2d Cir. 1993); *Bricklayers Local No. 1 Welfare Fund v. Louisiana Health Ins. Assoc.*, 771 F. Supp. 771, 14 E.B.C. 1529 (E.D. La. 1991); *United Health Services, Inc. v. Upstate Administrative Services*, 573 N.Y.S.2d 851, 14 E.B.C. 1301 (N.Y.S. Sup. Broome Cty. 1991). Notably, even the Second Circuit, author of the *Rebaldo* decision, has abandoned its prior decision. *Smith v. Dunham-Bush, Inc.*, 959 F.2d 6, 9 n.3 (2d Cir. 1992).

Health care reform is a pressing issue in the 1990's and states will increasingly experiment with solutions to the health care crisis. This experimentation, nevertheless, must remain within parameters that do not unfairly and disproportionately burden ERISA welfare funds. By creating an outright exception to the ERISA preemption doctrine for health care regulation, the Third Circuit Court of Appeals has given states an open invitation to extract money from ERISA funds to subsidize the cost of health care for all segments of society.

In New Jersey alone in 1992 some $450 million was diverted from ERISA funds to subsidize the cost of

medical care for non-ERISA beneficiaries. (37a) When the Court considers that more than 30 states either have existing or pending legislation enacting systems similar to New Jersey's. 138 Cong. Rec. S13267-02 (Sept. 10, 1992). It becomes obvious that the nationwide financial impact of the Third Circuit's decision will undermine every purpose that Congress sought to achieve in enacting ERISA. A pandora's box of state regulations will open to tap ERISA funds as a means to pay for social programs for non-ERISA participants. As aptly stated by Judge Nygaard in his dissenting opinion:

> I fear that the majority gives States free reign to spend and experiment with ERISA funds, held in trust for the many workers who have labored long for their security, in noble pursuit of health care reforms so long as States exercise a minimum degree of imagination by couching their statutes in "generally applicable" terms.

(43a-44a)

In short, the decision by the Third Circuit cannot be what Congress intended. If left to stand, the result will be a plethora of new legislation (followed by more litigation) targeted to extract from ERISA funds a disproportionate share of our country's health care bill and the undermining, if not possible collapse, of the ERISA welfare fund system.

III. The New Jersey Hospital Billing Scheme "Relates To" ERISA Welfare Funds And Has More Than A "Tenuous, Remote Or Peripheral" Effect On The Welfare Funds[7]

There is no doubt that the challenged surcharges have an enormous financial impact upon the Welfare Funds. In fact, the enormous financial role played by ERISA funds in the New Jersey hospital funding scheme is best exemplified by the State of New Jersey's admission that "the scheme is not 'viable' without money from the plans." (35a) It is impossible to argue logically, given this admission, that the legislation does not "relate to" the ERISA Welfare Funds.

The shear enormity of the surcharges has forced plans to either increase the level of contributions required to meet the participants' welfare needs, reduce the level of benefits available, or deplete the assets of the Welfare Funds. For every dollar paid by the Welfare Funds to subsidize the care of non-participants, the Funds are forced to reduce benefits provided or attempt to pass along the increased costs to its participants, either directly or indirectly through the renegotiation of collective bargaining agreements. Such effect clearly

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[7] Three specific references are contained in the hospital rate setting scheme referring to ERISA welfare plans. Two references are contained in the Patient Appeal Policy. The third reference to such plans is contained in the Act itself. (36a-37a) These references *alone* constitute sufficient basis to find the statute preempted. *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 47 (1987). *See also Ingersoll-Rand*, 498 U.S. at 138-139; *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 739 (1985); *Shaw*, 463 U.S. at 97.

relates to the Welfare Funds. *See In re Morgan Guaranty Trust Co. of N.Y.*, 80 N.Y.2d 44, 52, 599 N.E.2d 656, 661, 587 N.Y.S.2d 252, 257 (N.Y. Ct. of Appeals 1992) (statute of general application which "directly deplete funds otherwise available for providing benefits flies in the face of ERISA's goal of assuring the financial soundness of such plans").

In *E-Systems, Inc. v. Pogue*, 929 F.2d 1100 (5th Cir. 1991), *cert. denied*, 112 S. Ct. 585 (1991) a Texas statute which imposed a 2.5% annual tax on ERISA welfare benefit plans was found preempted. The court held that economic impact *alone* was adequate grounds to find a "connection with" such plans. The court noted that the tax:

> reduce[d] future assets and the capability of the plans to pay benefits. The cost of the plan must therefore increase for the employer and/or employees or the benefits must be adjusted downwards to offset the tax bite. This is the type of impact Congress intended to avoid when it enacted the ERISA legislation.

Id. at 1103. *See also The Travelers Ins. Co. v. Cuomo*, 813 F. Supp. 996 (S.D.N.Y. 1993) (surcharges applied to New York hospital bills were preempted because of the substantial economic impact the surcharges had on ERISA plans and the diversion of plan resources from the intended ERISA beneficiaries); *In re Morgan Guaranty*, 80 N.Y.2d at 51-52; *R.R. Donnelley & Sons Co. v. Provost*, 915 F.2d 787, 791-92 (2d Cir. 1990), *cert. denied*, 111 S. Ct. 1415 (1991) (recognizing preemption based on economic impact).

The impact of these surcharges is more extensive than financial alone. The diversion of ERISA funds to pay for the care of non-ERISA patients stands in direct conflict with the express intent of Congress to protect the interests of participants in employee benefit plans. Pursuant to ERISA, 29 U.S.C. § 1103(c)(1):

> the assets of a plan . . . shall be held for the exclusive purpose of providing benefits to participants in the plan and their beneficiaries . . . [8]

Thus, Congress has expressed a clear intent that Welfare Fund moneys be used strictly and exclusively for the benefit of the plans' beneficiaries. Contrary to this express purpose, the surcharges, by both design and effect, divert ERISA funds to subsidize and support the cost of medical care for non-plan members. Similar hospital surcharges to subsidize the care of non-participants have been held preempted by ERISA. *See Bricklayers Local No. 1 Welfare Fund v. Louisiana Health Ins. Assoc.*, 771 F.Supp. 771 (E.D. La. 1991).

Moreover, in addition to reducing funds available for plan beneficiaries, the challenged surcharges have forced the Welfare Funds to alter benefits provided and have interfered with the coordination and administration of interstate benefits. As an example, United Wire's plan

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[8] Additionally, 29 U.S.C. § 186(c)(5) conditions ERISA welfare funds' receipt of contributions from employers on such payments being "held in trust for the purpose of paying, . . . for the benefit of employees, their families and dependents, for medical or hospital care." *See also* 29 U.S.C. §§ 1002, 1103(a) and 1103(c)(i). This provision further limits the use of such funds for the sole and exclusive benefit of the employees of such employer and their families and dependents.

provides full coverage for hospital services provided in states other than New Jersey. However, because of the enormous surcharges imposed in New Jersey, the Fund has been forced to alter its benefits within New Jersey to provide less than full coverage. As a matter of black letter law, ERISA forbids a statutory scheme which forces an ERISA plan to apply differently to otherwise identically situated beneficiaries who live in different states, *PPG Indus.*, 902 F.2d at 1151; *Local Union 598*, 846 F.2d at 1219; *Shaw*, 463 U.S. at n. 20, n. 25, and preempts state laws which interfere with the administration of benefits. *Bricklayers Local No. 1 Welfare Fund v. Louisiana Health Ins. Assoc.*, 771 F. Supp. 771 (E.D. La. 1991) (a two dollar surcharge on hospital bills of all insured patients, which surcharge was used to benefit non-members, affected the administration of the plan); *Greater Washington Bd. of Trade v. District of Columbia*, 948 F.2d 1317, 1325 (D.C. Cir. 1991), *aff'd*, 113 S. Ct. 580 (1992); *Birdsong v. Olsen*, 708 F. Supp. 792, 801 (W.D. Tex. 1989).

Based upon the enormity of the economic impact of the challenged surcharges on the Welfare Funds, the administrative burdens imposed upon the Welfare Funds, and the interference created with uniformity of benefits, a conclusion that the New Jersey hospital rate setting scheme is preempted by ERISA is inescapable.

CONCLUSION

In light of the broad implications that flow from the incorrect decision by the Third Circuit, it is respectfully requested that this Court grant a Writ of Certiorari.

Dated: Roseland, New Jersey
August 4, 1993

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In The

Supreme Court of the United States

October Term, 1993

NYSA-ILA WELFARE FUND, *et al.*,

Petitioners,

vs.

FRANCIS J. DUNSTON, in her capacity as NEW JERSEY COMMISSIONER OF HEALTH, *et al.*,

Respondents.

*On Petition for Writ of Certiorari to the United States Court of Appeals for the Third Circuit**

BRIEF IN OPPOSITION FOR RESPONDENT NEW JERSEY HOSPITAL ASSOCIATION AND THE RESPONDENT HOSPITALS

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* Case captions for additional petitions are referenced on inside front cover.

BEST AVAILABLE COPY

NEW JERSEY CARPENTERS WELFARE FUND, *et al.*,

Petitioners,

vs.

FRANCES J. DUNSTON, in her capacity as NEW JERSEY COMMISSIONER OF HEALTH, *et al.*,

Respondents.

TRUSTEES OF THE WELFARE TRUST FUND, LOCAL UNION NO. 475, *et al.*,

Petitioners,

vs.

FRANCES J. DUNSTON, in her capacity as NEW JERSEY COMMISSIONER OF HEALTH, *et al.*,

Respondents.

UNITED WIRE, METAL & MACHINE HEALTH AND WELFARE FUND, *et al.*,

Petitioners,

vs.

MORRISTOWN MEMORIAL HOSPITAL, *et al.*,

Respondents.

QUESTIONS PRESENTED FOR REVIEW

1. Whether the Court of Appeals correctly applied this Court's prior precedents in holding that a generally applicable hospital rate setting statute which is not intended to regulate the conduct of self-insured employee benefit plans, does not single out such plans for special treatment, does not predicate rights and obligations upon the existence of such plans and does not dictate or restrict the manner in which such plans administer their affairs, is not preempted by the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1001, *et seq.*

2. Whether the Court of Appeals correctly applied this Court's prior precedents in holding that a generally applicable hospital rate setting statute which adjusts the benefits and burdens of economic life to promote the common good, does not impact upon plan participants in an inappropriate way and which constitutes a continuation of New Jersey's long standing regulation of health care matters, does not cause a taking of property without just compensation in violation of the Fifth Amendment of the United States Constitution.

PARTIES TO THE PROCEEDINGS

All parties to these proceedings appear in the caption of the decision of the United States Court of Appeals for the Third Circuit, which is contained in petitioners' appendix at pages A-1 through A-5. Because of the large number of parties, the list will not be reproduced herein. In accordance with Supreme Court Rule 29.1, a list of the respondents' parent corporations and subsidiary corporations that are not wholly owned is reproduced in the appendix to this brief.

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STATEMENT OF THE CASE

This case involves the issue of whether certain components of New Jersey's comprehensive statutory scheme governing hospital rate setting are preempted by ERISA, 29 U.S.C. § 1001, *et seq.*, or create an unlawful taking of property without just compensation in violation of the Fifth Amendment to the United States Constitution.

A. Hospital Rate-Setting in New Jersey

New Jersey's Health Care Facilities Planning Act, N.J.S.A. 26:2H-1, *et seq.* (the "Act") was enacted by the New Jersey Legislature in 1971.[1] The declared public policy underlying the Act was:

> that hospital and related health care services of the highest quality, of demonstrated need, efficiently provided and properly utilized at a reasonable cost are of vital concern to the public health.

N.J.S.A. 26:2H-1 (1992).[2] (Respondents' Appendix, *infra*, at A-8). In order to attain cost-containment and efficiency, the Act authorized the Commissioner of the New Jersey Department of

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1. On November 30, 1992, the Legislature enacted the Health Care Reform Act of 1992, L. 1992, ch. 160. As a result of this legislation, the State of New Jersey no longer regulates the establishment of hospital rates. While the specific statutory provisions challenged herein have been superseded, petitioners seek restitution of monies paid while those provisions were in effect, and many hospitals have not been paid in full for services rendered pending the final outcome of this litigation. As a result, the Court of Appeals determined that this case was not moot.

2. Pertinent sections of the Act have been reproduced in respondents' appendix.

Health (the "Commissioner") to regulate certain costs of health care services, including the establishment of hospital rates. N.J.S.A. 26:2H-5, 26:2H-18, and 26:2H-18.1 (1992) (Resp. A-15-23).

As originally enacted in 1971, the Act authorized the Commissioner to set hospital rates only for individuals whose care was paid for by Blue Cross and certain governmental programs, such as Medicaid. L. 1971, c. 136, § 18. (Resp. A-23-24). The rates were based on the actual cost of services provided by hospitals, a method which furnished only limited incentives to improve efficiencies in hospital operation. Under the 1971 Act, the state had no authority over the rates that hospitals charged patients who had private insurance coverage or the uninsured. Consequently, these groups sometimes paid higher rates for the same services. *See generally Borland v. Bayonne Hospital,* 72 N.J. 152, 159 (1977), *cert. denied,* 434 U.S. 817 (1977).

In order to achieve greater control over the increasing cost of hospital services, reduce the disparity in rates charged to patients whose care was fully or partially paid for by different payors, and alleviate the financial burden on hospitals serving indigent patients, the New Jersey Legislature amended the Act by establishing a new system of hospital rate-setting controlling charges to all patients receiving hospital services. L. 1978, c. 83.[3] Unlike the former system, Chapter 83 applied to all payors, not just to individuals whose care was paid for by Blue Cross and Medicaid. Chapter 83 contained an express recital that cost containment was a stated objective of the Act. N.J.S.A. 26:2H-1 (1992). (Resp. A-8). The statute also had an express goal of promoting the fiscal solvency of hospitals. *Id.* Administration of the new rate-setting system was delegated to the New Jersey Department of Health ("DOH").

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3. These amendments have become known as "Chapter 83".

The rate-setting system set a prospective rate of reimbursement, in advance of actual treatment, which was a blend of the statewide mean/standard costs developed by looking at the resources consumed by the industry as a whole and the hospital-specific resources and costs consumed in treating particular illnesses, categorized as diagnosis related groups ("DRG"). N.J.A.C. 8:31B-5.1. Each DRG reflected a wide variety of both direct and indirect patient care costs. N.J.A.C. 8:31B-3.4. These costs were derived from actual costs incurred by all acute care hospitals during a particular base year, as updated for inflation and certain other factors. N.J.A.C. 8:31B-2.5.[4] The quantification of these costs into certain "financial elements" were used to develop each hospital's "preliminary cost base" and schedule of rates. N.J.A.C. 8:31B-3.16.

The "preliminary cost base" was defined as that portion of a hospital's actual, current costs which may reasonably be required to be reimbursed to a properly utilized hospital for the efficient and effective delivery of appropriate and necessary health care services of high quality required by such hospital's mix of patients. N.J.S.A. 26:2H-2.k (1992). (Resp. A-11). Each hospital received a blend of its own costs and the mean/standard costs developed by looking at the hospital industry as a whole. N.J.A.C. 8:31B-3.5. Direct patient care costs in excess of the blend of the hospital's own costs and the mean/standard costs were "disincentives" which were excluded from a hospital's rates. Where, however, a hospital's costs were below the standard, the hospital nevertheless

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4. In employing a DRG-based methodology, New Jersey's hospital rate-setting system was similar to the hospital reimbursement system employed by the Medicare program. Indeed, Medicare's DRG-based methodology was developed as a result of a review of demonstration projects employing this methodology undertaken by the States of New Jersey and New York under the authority of the Secretary of the U.S. Department of Health and Human Services. *See* H.R. Rep. No. 25, 98th Cong., 1st Sess. 145, *reprinted in* 1983 U.S. Code Cong. & Ad. News 143, 364.

received a proportion of the standard costs, thereby gaining an increase or "incentive" in its rates. N.J.A.C. 8:31B-3.23(a).

The prospective nature of the rate-setting system and its reliance on illness-related diagnosis related groups precluded the establishment of rates that relied on a particular individual's length of stay, treatment and consumption of resources. For example, if a patient was admitted for an appendectomy, a hospital could only charge the patient the amount approved for the DRG classification of appendectomy, and not the actual cost of all services provided to the patient. Thus, the amount approved for a DRG classification could actually be lower or higher than the actual cost of the services that the patient received.

Each hospital's schedule of rates, defined as the amount which each hospital was permitted to charge per DRG, was approved by New Jersey's Hospital Rate Setting Commission ("HRSC"), at a level sufficient to generate the amount of revenue required to cover the revenue requirements of the preliminary cost base.

1. Uncompensated Care

Among the costs of doing business incurred by hospitals operating within New Jersey are costs associated with the provision of services to individuals who are unable to pay. These costs are known as uncompensated care costs, incurred as a result of a statutory requirement which specified that "access to quality health care shall not be denied to residents of the state because of their inability to pay for the care." L. 1991, c. 183, § 1. (Resp. A-24-25). Federal law similarly requires treatment of such patients. Under 42 U.S.C. § 1395dd, hospitals must treat and stabilize individuals in need of emergency care and women in active labor regardless of whether or not they can pay. In addition, a state licensure standard, N.J.A.C. 8:43G-5.2(c), specifies that hospitals "shall not deny admission to patients on the basis of their inability

to pay", while N.J.A.C. 8:43G-4.1(a)2 requires every New Jersey hospital patient be accorded the right to "treatment and medical services without discrimination based on race, age . . . ability to pay, or source of payment."

When Chapter 83 was originally enacted, uncompensated care costs which a particular hospital incurred were borne entirely by that particular hospital's patients. Each hospital factored in uncompensated care costs as a component of its rates in order to meet this cost of doing business. As a result, hospitals serving a large population of indigent patients were forced to charge significantly higher rates than hospitals providing less uncompensated care. The provision of a high proportion of uncompensated care threatened the financial stability of hospitals with high uncompensated care case loads.

New Jersey's hospital reimbursement system sought to alleviate the financial burdens imposed on hospitals through their provision of unreimbursed care by requiring the cost of providing such care to be considered in hospital rates charged to all patients. Thus, N.J.S.A. 26:2H-18.d expressly provided that the reasonable costs of hospital services to indigent patients and bad debts were mandatory financial elements of a hospital's preliminary cost base which were to be included in the rates charged to all non-federal payors. (Resp. A-20).

Monies utilized to reimburse hospitals for the provision of uncompensated care were collected through the imposition of a uniform charge which was added to each patient's hospital bill. The uniform charge amounts collected from all patients were then remitted by the hospitals to a Trust Fund. All monies remitted to the Fund were appropriated to the state Medicaid agency, which would then reimburse hospitals for the amount of uncompensated care that they actually provided.

2. The Medicare Cost Shift

Under N.J.S.A. 26:2H-18.1.c. (1992) (Resp. A-22), hospital rates were also permitted to account for adjustments that resulted from statutes and regulations affecting the delivery of health care. Such adjustments were required to take into account the effectiveness and efficiency of the health care delivery system as a whole. The federal Medicare program does not pay the same rates as were provided for under the New Jersey DRG reimbursement system, since Medicare payment rates are established under a separate federal statutory scheme. *See* 42 U.S.C. § 1395c *et seq.* Accordingly, DOH created adjustments in the rates paid by non-Medicare patients to account for the shortfall between what Medicare would pay and the New Jersey DRG rate. N.J.A.C. 8:31B-3.73. This was known as the "Medicare cost shift."

3. Payor Differentials

The HRSC was also permitted to grant differentials in payment rates to a payor or class of payors. N.J.S.A. 26:2H-18.b (1992) (Resp. A-18-19). If the HRSC granted a payor differential, it had to be supported by evidence of "quantifiable economic benefits rendered to the institution or to the health care delivery system taken as a whole." Under the authority of this provision, a differential from the DRG rate was accorded to patients who had health benefits coverage through certain payors, such as Blue Cross and Blue Shield, as a result of the financial benefits to society which are provided by the open enrollment programs offered by such payors. The differentials were allocated among patients covered by all payors other than Medicare so that a hospital received from all payors net revenue equal to its preliminary cost base.

B. ERISA Preemption

The Employee Retirement Income Security Act, popularly

known as ERISA, 29 U.S.C. § 1001, *et seq.*, was enacted in 1974. The subject of the ERISA statute is pension benefit plans and employee benefit plans. ERISA contains a preemption clause which provides that ERISA "shall supersede any and all state laws insofar as they may now or hereafter relate to any employee benefit plan" which is covered by ERISA. 29 U.S.C. § 1144(a).[5] The statute defines the term "state" to include any political subdivision, agency or instrumentality of a state, while state law was defined to include all laws, decisions, rules or regulations or other state action having the effect of law. 29 U.S.C. §§ 1144(c)(1), 1144(c)(2).

C. Decisions Below

Commencing in 1990 and continuing through the first half of 1992, over a dozen self-insured employee benefit plans ("the Plans") and a number of individual Plan participants commenced a series of civil actions (later consolidated) against the State of New Jersey and most of the state's acute care hospitals seeking an injunction against the application to them of New Jersey's hospital rate setting statute. The Plans and their participants alleged that certain provisions of the statutes and regulations applicable to hospital rate setting were preempted by ERISA, denied the Plans and their participants due process and equal protection under the New Jersey and United States Constitutions, violated the Fifth Amendment of the United States Constitution by creating a taking of property without just compensation, and created an unlawful tax and delegation of taxing authority. In particular, the Plans challenged the inclusion in hospital rates of: (1) the uncompensated care add-on; (2) the Medicare cost shift; and (3) payor differentials.

On May 27, 1992, the District Court issued an Opinion and Order which provided for the entry of a permanent injunction

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5. This provision is also referred to as Section 514(a).

against the state defendants. (Pet. A-64-95). The District Court enjoined enforcement of New Jersey's hospital rate setting statute and regulations to the extent that they allowed for the inclusion in hospital rates charged to ERISA-covered plan participants of costs attributable to the provision of uncompensated care, the Medicare cost shift and payor differentials. While the court acknowledged that no court had extended ERISA preemption to the extent of its opinion, the court found that New Jersey's hospital rate setting statute "related to" ERISA plans, even though the statute did "not mention benefit plans directly and [did] not regulate the terms and conditions of any such plans explicitly". (Pet. A-80). The court rejected the plans' constitutional claims. (Pet.A-85-92). The injunction was stayed pending appeal. (Pet. A-19).

On May 14, 1993, the Court of Appeals reversed the decision of the District Court. (Pet. A-1-61). The Court of Appeals concluded that New Jersey's hospital rate setting law constituted a generally applicable law which (1) is not intended to regulate the affairs of ERISA plans; (2) neither singles out such plans for special treatment nor predicates rights or obligations on the existence of an ERISA plan; and (3) does not have the effect of either dictating or restricting the manner in which ERISA plans structure or conduct their affairs or impairing their ability to operate simultaneously in more than one state. The Court of Appeals expressed an unwillingness "to attribute to Congress and Section 514 an intent to frustrate the efforts of the State, under its police power, to regulate health care costs." The court concluded that it had found no case that had held a law fitting the characteristics of the New Jersey hospital rate setting statute to be preempted by ERISA, and it would decline to so hold. (Pet. A-30).

The Third Circuit also soundly rejected the Plans' claims that the challenged costs did not constitute an unlawful taking of property without just compensation and affirmed the District Court's summary judgment for the defendants as to the Plans'

constitutional claims.[6] (Pet. A-22-23).

REASONS FOR DENYING THE WRIT

I.

REVIEW BY THIS COURT IS NOT AVAILABLE BECAUSE THE COURT OF APPEALS HAS NOT DECIDED A FEDERAL QUESTION IN A WAY THAT CONFLICTS WITH APPLICABLE DECISIONS OF THIS COURT.

Under Rule 10.1(c) of the Rules of the Supreme Court, a Petition for a Writ of Certiorari may be granted if a United States Court of Appeals has decided a federal question in a way that conflicts with applicable decisions of this Court. No such conflict has occurred as a result of the Third Circuit's decision in *United Wire*. Petitioners' efforts to convince this Court otherwise misconstrues the Court's earlier, consistent holdings that only state statutes which impact on ERISA benefit plans, not plan benefits or plan beneficiaries, are subject to preemption by ERISA.

Under ERISA preemption analysis, a law "relates to" an employee benefit plan if it has a connection with or reference to such a plan. *Shaw v. Delta Airlines, Inc.*, 463 U.S. 85, 96-97 (1983). A state law that either directly or indirectly refers to, or otherwise attempts to or succeeds in regulating or interfering in the administration of employee benefit plans, relates to ERISA and is preempted. *Fort Halifax Packing Company, Inc. v. Coyne*, 482 U.S. 1, 7-8 (1987). As recently as last term, however, this Court reiterated that preemption does not occur if a state law has only a "tenuous, remote or peripheral connection with covered plans, . . . as is the case with many laws of general applicability." *District of*

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6. Petitioners' equal protection, due process and tax law claims were neither raised nor considered on appeal.

Columbia v. Greater Washington Board of Trade, 113 S. Ct. 580, 583 n. 1 (1992). *See also Ingersoll- Rand v. McClendon,* 498 U.S. 133, 139 (1990); *Shaw,* 463 U.S. at 100, n. 21.

Under the plain language of the statute and this Court's precedents, there *must* be a nexus between the ERISA-covered plan and the state statute, regulation or cause of action being challenged. In the absence of such a nexus, there can be no finding of ERISA preemption. For example, in *Fort Halifax,* this Court declined to find preemption of a Maine statute requiring employers to provide a one-time severance payment to employees in the event of a plant closing. As the Court noted, a crucial feature of ERISA's preemption provision is its deliberate use of the term "employee benefit plan." While the appellants in *Fort Halifax* argued that any state law pertaining to an employee benefit listed in ERISA necessarily regulates an employee benefit plan, the Court rejected this distinction, finding the choice of words employed by Congress to be deliberate:

> Nothing in our case law, however, supports appellant's position that the word "plan" should in effect be read out of the statute . . . The words "benefit" and "plan" are used separately throughout ERISA, and nowhere in the statute are they treated as the equivalent of one another. Given the basic difference between a "benefit" and a "plan", Congress' choice of language is significant in its preemption of only the latter.

Fort Halifax, 482 U.S. at 8. Similarly, in *Mackey v. Lanier Collection Agency,* 486 U.S. 825 (1988), this Court refused to find George's general garnishment statute to be preempted, even though the statute at issue prevented plan participants from receiving their benefits and even though complying with garnishment orders might burden the administration of the plan.

In *Ingersoll-Rand Company v. McClendon*, 498 U.S. 133 (1990), this Court considered a state cause of action which allowed former employees to bring wrongful discharge suits based upon the fact that the alleged reason for discharge was a desire not to make payments to the employee out of an employee benefit plan. Although the Court concluded that the state cause of action was preempted by ERISA, the Court nevertheless reiterated that there are limits to ERISA preemption. The Court reaffirmed its earlier determination in *Fort Halifax* that under the plain language of the ERISA statute, only state laws that relate to benefit *plans* are preempted. *Ingersoll-Rand*, 498 U.S. at 139. The Court also noted that under its decision in *Mackey*, the fact that collection might burden the administration of a plan did not, by itself, compel preemption. In finding that the state cause of action considered in *Ingersoll-Rand* was preempted by ERISA, the Court drew the following distinction between laws that are preempted by ERISA and those that are not:

> We are not dealing here with a generally applicable statute that makes no reference to, or indeed functions irrespective of, the existence of an ERISA plan, nor is the cost of defending this lawsuit a mere administrative burden. Here, the existence of a pension plan is a critical factor in establishing liability under the state's wrongful discharge law.

Id. at 139-140. Thus, the Court did not retreat from its earlier holdings that ERISA preemption is not without limits and that laws which operate irrespective of the existence of ERISA plans can survive a preemption challenge.

The Third Circuit's decision is entirely consistent with this Court's prior decisions regarding the scope of ERISA preemption. The court analyzed the impact that New Jersey's rate setting statute had on ERISA plans and concluded that the requisite nexus

between the challenged statute and the plans was lacking in this case. This was entirely appropriate, since all that New Jersey's hospital rate setting scheme did was to establish a methodology of setting hospital rates which calculated the price charged to hospital patients for the services that they received irrespective of whether or not they possessed health benefits coverage.[7] As the Third Circuit correctly found, New Jersey's hospital rate setting statute never dictated what an employee benefit plan must pay, and did not require ERISA plans to cover a plan participant's total hospital costs. Under the statutory and regulatory scheme, plans remained free to set their benefit levels without any reference to the state-regulated DRG rate, and were free to pay whatever portion of an individual's hospital bill they deemed appropriate.[8] While the rate-setting system did impact upon the price for hospital services paid by plan participants, the system did not impose any requirements on the plan itself.

Petitioners argue that there is a direct impact on the plan because of the economic impact that payment of the challenged

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7. Even individuals who were uninsured had amounts attributable to uncompensated care, the Medicare cost shift and payor differentials included in the rates they were charged by hospitals.

8. The provision of uncompensated care originates in part from federal requirements specifying that hospitals must provide indigent care. 42 U.S.C. § 1395dd mandates hospitals to treat and stabilize individuals experiencing emergency conditions (including women in active labor) irrespective of their ability to pay. In addition, regulations under the federal Hill-Burton program preclude hospitals receiving Hill-Burton funding from denying emergency services to persons residing in the facility's service area due to an inability to pay. *See* 42 C.F.R. § 124.603. The uncompensated care add-on represented a mechanism developed by the state to compensate hospitals for the costs of providing these services. It would be inconsistent to find that one federal law would preclude hospitals from recovering revenues needed to comply with the requirement that they provide uncompensated care at the same time that another federal law mandates that hospitals provide such care.

add-ons had on the plan and plan participants. This overlooks the fact that this Court has never found a statute to be preempted simply because it increases the price paid by plan participants for a particular commodity.[9]

Petitioners' analysis reflects a fundamental misunderstanding of the mechanics of setting a price for hospital services. The cost of providing uncompensated care and of discounts provided to certain payors is no different from any other type of cost that hospitals incur. As the Third Circuit accurately observed, a state's imposition of this cost of doing business is:

> No different in kind, however, from any state regulation that increases the cost of goods or services that hospitals consume and pass on in hospital costs, i.e. utility costs, the wages of its employees, waste disposal costs, etc.

(Pet. A-26). In this regard, hospitals function just like any other business, where prices established include not only operating expenses but sufficient markup to cover theft, spoilage and discounts provided to wholesale customers or during promotional events. The payment of these costs does not constitute a payment for the benefit of others, as petitioners allege, but merely represents reimbursement to the hospitals to cover their costs of doing business.

The fact that compliance with a state statute might indirectly increase plan costs was held not to be a sufficient ground for

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9. Petitioners assert that New Jersey's statute thwarted the express purpose of their plans because many plans have a purpose of paying 100% of a participant's hospital bill. While this is a laudable goal, the State cannot be required to set hospital rates at a level that will permit third party payors to cover the full amount of a patient's bill. The issue raised by petitioners is an economic issue, not an ERISA preemption issue.

preemption in this Court's earlier decision in *Mackey*, where a Georgia garnishment law was found not to be preempted by ERISA despite the fact that "substantial administrative burdens and costs" were incurred by the plans in complying the statute. *Mackey*, 486 U.S. at 831-32. Given the result in *Mackey*, the Third Circuit's conclusion that New Jersey's statute is not preempted despite the fact that it may increase the charges billed to ERISA plan participants for hospital services is entirely consistent with this Court's prior decisions in this area.

No hospital bill purports to represent the actual cost of treating a particular individual. There are many types of costs incurred by hospitals that must be passed on to their patients which do not necessarily relate to the specific resources that the particular patient consumes. For example, hospital rates include amounts attributable to capital costs incurred by hospitals for improvements to a hospital facility. If a hospital constructs a pediatrics wing, it can include some of the costs attributable to this construction and the debt service payments associated with it in its rates. Thus, a 45 year old hospitalized for knee surgery may be paying a small portion of the costs attributable to the construction of a new pediatrics wing in his rates, even though this individual would not receive any services in that wing. The Third Circuit concluded that it is impossible for hospitals to set their prices in such a way as to only provide a bill for the specific services rendered to an individual patient. (Pet.A-31). This conclusion does not conflict with any prior decision by this Court. Nothing in this Court's earlier decisions can be read as standing for the proposition that ERISA plan participants may only be required to pay those components of a price which relate specifically to identifiable goods and services actually consumed by the plan participant.

The petitioners candidly admit that they do not challenge the underlying DRG reimbursement feature of New Jersey's hospital reimbursement statute, an admission that is fraught with an inherent and obvious contradiction. Under the DRG system, a

price was set for a particular type of service irrespective of the length of time that the patient stays in the hospital. Thus, a patient hospitalized for an appendectomy would receive the same bill irrespective of whether the patient stayed in the hospital 2, 4 or 6 days, absent any complicating factors which would have justified an additional payment. Because this system is based on an average cost per case, and not the actual cost incurred by a particular patient, utilization of a DRG system means that all patients will have costs included in their hospital rates which are attributable to others. Indeed, participants in the petitioners' plans directly benefited from this system of averages if they stayed in the hospital longer than the average period of time for a particular DRG, since the DRG would be calculated based upon a review of the costs associated with the average number of days of hospitalization for that illness. The very foundation of a DRG-based system is the provision of positive and negative incentives for hospitals to reduce costs. Petitioners cannot be permitted to selectively retain the benefits of the state's efforts to make health care affordable, while avoiding any perceived burdens in participating in the system. In either case, the State's pricing structure affects the relationship between the hospital and the plan participant, not the relationship between the hospital and the plan.

Petitioners assert that they are forced to subject their plan to conflicting forms of administration and that they are forced to abide by inconsistent regulations. However, the record is devoid of any evidence that hospital rates are uniform among all other states, and that New Jersey is somehow unique. The cause of the administrative difficulties and inconsistencies referenced by petitioners does *not* flow from the peculiar features of New Jersey's hospital rate setting system, but the fact that hospital prices can vary substantially among different states, or even within different geographic regions of a particular state. Hospital rates will, of necessity, be affected by such varying factors as differences in wage costs, as well as differences in the price of purchasing the commodities used by hospitals. As the Third Circuit

noted, the petitioners would always be subject to these inherent inconsistencies, regardless of the nature of the reimbursement system utilized or the components contained therein.

The petitioners' flawed analysis also overlooks the fact that the challenged components of the DRG rate are components of hospital rates in all states, not just New Jersey. Several other states which regulate hospital rate-setting include the cost of providing uncompensated care in the rates. *See, e.g.*, N.Y.P.H.L. § 2807-c. The Third Circuit's conclusion that state regulation of hospital pricing is not likely to make interstate operation of an ERISA plan more difficult is entirely consistent with this Court's prior decisions. This Court has never held that either ERISA-covered plans or their participants must be permitted to pay the same price for a particular service in different states, even though there may be legitimate reasons for prices varying from one state to another. Hospitals which set their own rates in a non-regulated setting include costs attributable to charity care, bad debt, Medicare shortfalls and payor discounts in their rates as costs of doing business. Indeed, the District Court acknowledged this by stating that "Even if New Jersey did not enact Chapter 83, hospitals would still charge plaintiffs for uncompensated care . . . so that they could comply with their statutory obligations to provide hospital care for everyone regardless of that person's ability to pay." (Pet.A-92). It defies logic to suggest that costs which would normally be included in hospital charges in the absence of state regulation cannot be included in the rates charged to ERISA plan participants if the same costs are established pursuant to state statute. To find New Jersey's system to be preempted by ERISA would raise a serious question regarding the ability of a state to take *any* action regarding regulation of hospital rates, since the mere action of setting rates which will be paid by participants in ERISA-covered plans could arguably cause such plans to structure benefits in a particular manner.

Petitioners assert that because the statute includes a reference

to "union welfare plan identification cards", the statute expressly references ERISA plans and is therefore preempted. The reference in question simply provides that a hospital shall not be reimbursed for the cost of providing uncompensated care unless it interviews each patient admitted to determine whether the patient is covered by health insurance, as documented by such items as "a union welfare plan identification card or claim form." N.J.S.A. 26:2H-18.31. All that the statute does is require verification of whether third party insurance is available to pay all or part of a patient's bill. It does not regulate the amount of coverage or set the rate that must be paid, and does not impose any additional burdens upon plan administrators. In short, this provision causes no impact on the plan at all, whether direct or indirect. Thus, as the Third Circuit correctly found, this reference should be regarded as without legal consequence for preemption purposes, and is therefore distinguishable from the references contained in the statutes analyzed by this Court in its *FMC* and *District of Columbia* decisions.[10]

Petitioners also contend that their participants derived no benefit from the existence of the challenged components in New Jersey's hospital rates and that their participants bore a disproportionate share of the burden in covering these costs. It is not true that plan participants derived no benefit from inclusion of these costs in hospital rates. Without coverage of these legitimate business costs, hospitals could not survive. Therefore, plan participants did derive a direct benefit from these costs because payment of these costs helped to provide hospitals with sufficient cash flow to keep their doors open.

New Jersey's hospital rate setting statute did place a large

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10. The references to self-funded union plans in the Department of Health's Patient Appeal Policy also should not result in a finding of preemption. The Patient Appeal Policy does not regulate the plans or the rates they are charged, or cause any impact on the plan administrator.

share of the burden of paying for uncompensated care upon individuals who have the resources to pay for such care. However, while the fact that individuals who pay for hospital services bear a larger share of the overall cost of providing such services may be unfair or debatable from a social policy point of view, this does not give rise to a violation of ERISA. Plainly, ERISA does not address the rights of plan participants as consumers. As this Court has repeatedly held, the only impact the ERISA preemption provision is concerned with is the impact that a statute or a state cause of action has on the plan itself. The Third Circuit's decision is, therefore, in full accord with this Court's prior decisions respecting ERISA preemption, since the Third Circuit concluded that any impact on the plan itself, a necessary prerequisite to a finding of ERISA preemption, was absent here.

II.

THE THIRD CIRUIT'S DECISION IS NOT IN CONFLICT WITH THE DECISION OF ANOTHER UNITED STATES COURT OF APPEALS.

Under Supreme Court Rule 10.1(a), this Court may exercise its discretion and grant a Petition for a Writ of Certiorari when a United States Court of Appeals has rendered a decision in conflict with the decision of another United States Court of Appeals on the same matter. The requisite conflict between the Circuits is lacking in this case. The only Court of Appeals decision to address an issue similar to those present in this case was *Rebaldo v. Cuomo*, 749 F.2d 133 (2nd Cir. 1984), a case whose reasoning was followed by the Third Circuit in reaching its decision in *United Wire*. While petitioners may seek to characterize other cases as being in conflict with the decision of the Third Circuit, these cases are either trial court decisions or deal with different issues and, therefore, do not create a direct conflict.

Rebaldo is the only Court of Appeals decision which deals

with the issue of ERISA preemption in the context of a review of a hospital rate setting statute. The statute at issue in *Rebaldo* prohibited hospitals from establishing inpatient charges for self-insured employee benefit plans that were different than the charges authorized by a state statute. The Second Circuit sustained the New York statute against an ERISA preemption challenge. The Second Circuit's decision in *Rebaldo* was premised upon two findings: (1) that a state statute cannot be found to be preempted by ERISA unless it "purports to regulate the terms and conditions of an employee benefit plan" and (2) that a state statute which constitutes a generally applicable exercise of a state's police powers should not be found preempted by ERISA if it only affects a plan in a tenuous, peripheral or remote manner. The Third Circuit followed the second prong of the *Rebaldo* court's analysis. Thus, there is uniformity among the circuits with respect to the issue of whether a generally applicable hospital rate-setting statute should be viewed as preempted by ERISA.

Petitioners attempt to gloss over the fact that no conflict between the circuits is present here by arguing that the decision in *Rebaldo* has been effectively overruled by subsequent decisions of this Court and other lower courts. *Rebaldo* and *United Wire* are the only circuit court decisions dealing specifically with the issue of whether a generally applicable hospital rate setting statute is preempted by ERISA. Even if it were assumed for the sake of argument that *Rebaldo* was no longer good law, all that this would mean is that *United Wire* would stand on its own as the only Court of Appeals decision dealing with this particular issue. Thus, the requisite conflict between the circuits would still be lacking.

Moreover, the portion of the *Rebaldo* decision upon which the Third Circuit relied has not been overruled. The *Rebaldo* court's first rationale for finding no preemption has been narrowed by this Court's decision in *Ingersoll-Rand,* which held that a state cause of action which was predicated on the existence of an employee benefit plan could be preempted even if it did not purport to

regulate the terms and conditions of ERISA plans. However, the Supreme Court has not overruled the second and more important prong of the Second Circuit's analysis in *Rebaldo*. The state cause of action at issue in *Ingersoll-Rand* was not a generally applicable law which functioned irrespective of the existence of an ERISA plan. Indeed, both in *Ingersoll-Rand* and the more recent *District of Columbia* decision, this Court was careful to make an express note of the fact that it was *not* dealing with a generally applicable statute which affected a plan in a "tenuous, remote or peripheral" manner. Thus, *Rebaldo* has not been overruled by subsequent decisions of this Court.

The portion of the *Rebaldo* holding relied on by the Third Circuit has also never been overruled by the Second Circuit. In *Aetna Life Insurance Company v. Borges*, 869 F.2d 142 (2nd Cir. 1989), *cert. denied*, 493 U.S. 811 (1989), the Second Circuit reaffirmed this portion of its *Rebaldo* holding. While there is a footnote in the Second Circuit's decision in *Smith v. Dunham- Bush Inc.*, 959 F.2d 6, 9 n.3 (2nd Cir. 1992) referencing *Rebaldo*, the Court noted only that *Rebaldo* could no longer be invoked for the proposition that a state law is preempted "only if it relates to and *purports to regulate an ERISA plan.*" (Emphasis in original). However, the court in *Smith* never addressed *Rebaldo's* holding that a generally applicable state law cannot be preempted if its relationship with an ERISA plan is too tenuous, remote or peripheral to satisfy the "relate to" test.

Petitioners attempt to create a conflict between the circuits where none exist by arguing that several courts have found state laws to be preempted even where they can be categorized as generally applicable state laws involving an exercise of the state's police powers. These cases do not involve an exercise of the state's police power to regulate health care matters, and while the statutes analyzed in these other cases were generally applicable exercises of the state's police power, they had a concrete and direct impact on the plan. Thus, the decisions in these cases have not overruled the

portion of the *Rebaldo* decision relied on by the Third Circuit, and do not create a conflict either with *Rebaldo* or with the Third Circuit's decision in *United Wire.*

For example, in *General Electric v. Department of Labor,* 891 F.2d 25 (2d Cir. 1989), the Second Circuit held that a state law which required an employer to either bring the cost of its prescribed benefits into equivalence with the cost of local prevailing benefits or to pay the additional cost directly to employees was preempted by ERISA. However, while a labor law could be characterized as a generally applicable exercise of the state's police powers, the majority opinion in *General Electric* did not analyze the statute's status as such a law. Moreover, the law's affect on the plan was neither tenuous nor remote, because the plan was specifically told that it either had to pay benefits or maintain detailed records showing that another form of equivalent compensation was provided. In contrast, New Jersey's hospital rate setting system neither required plans to provide a particular level of benefits nor required a plan to establish how its participants' health care costs are otherwise being paid for.

In *Arkansas Blue Cross and Blue Shield v. St. Mary's Hospital,* 947 F.2d 1341 (8th Cir. 1991), *cert. denied,* 112 S. Ct. 2305 (1992), the Eighth Circuit held that an Arkansas statute that allowed a plan participant to assign benefits to health care providers, thus forcing plans to honor all assignments of benefits made by plan participants, was preempted by ERISA. While the court stated in its opinion that a state law's relationship to traditional state authority was not relevant to the question of whether a state statute relates to ERISA plans, the court went on to determine that this factor "is a policy consideration useful in deciding borderline questions of ERISA preemption," and analyzed the state statute at issue by reviewing the state's interest in enforcing it. *Arkansas Blue Cross,* 947 F.2d at 1350. Moreover, unlike the statute at issue in this case, the statute analyzed in *Arkansas Blue Cross* directed

plan administrators where benefits could be paid. This was a direct requirement imposed on the plans, and thus clearly could not be said to impact plans in a tenuous or remote manner.

The Eighth Circuit relied on *Gilbert v. Burlington Industries, Inc.*, 765 F.2d 320, 327 (2nd Cir. 1985) and *Boise Cascade Corporation v. Peterson*, 939 F.2d 632 (8th Cir. 1991) as authority for its conclusion in the *Arkansas Blue Cross* case regarding ERISA preemption. In both of these cases, however, the courts found that in order to avoid preemption, a statute representing the exercise of a traditional police power must *also* affect a plan in only a tenuous, remote or peripheral manner. *Gilbert*, 765 F.2d at 327, *Boise Cascade*, 939 F.2d at 639. This is the same reasoning utilized by the *Rebaldo* court. These cases similarly cannot be relied on as authority for the proposition that a conflict in the circuits exists regarding *Rebaldo's* enduring premise.[11]

Petitioners also rely on several lower court decisions where a generally applicable hospital rate setting law was found preempted and argue that a conflict is created by the existence of these decisions. First of all, the existence of these cases does not warrant further review by this Court, since this Court's rules do not permit the Court to exercise its discretion and grant a Petition for a Writ of Certiorari when there is a conflict between a Court of Appeals and a

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11. Petitioners also reference *Bricklayers Local No. 1 v. Louisiana Health Insurance*, 771 F. Supp. 771 (S.D. La. 1991), a District Court case. There, a Louisiana statute required plans to pay a $2 service charge as part of an individual's hospital bill. The funds were utilized to fund a catastrophic health insurance program. The Louisiana statute made the patient's insurance arrangement directly responsible for payment of the service charges and further required that payment of these charges had to be a "mandated benefit covered by an individual's insurance plan." The District Court decided that the statute was preempted. The Louisiana statute did not affect the plans in a tenuous or peripheral manner, since the service charge was levied directly on the plan, and the plan had no discretion as to whether to pay it or not.

lower court. Secondly, the analysis employed to strike down the hospital rate setting statutes at issue in each of these cases is seriously flawed.

In *Traveler's Insurance Company v. Cuomo,* 813 F. Supp. 996 (S.D.N.Y. 1993), *appeal pending,* No. 93-7194 (2nd Cir.), a federal District Court in New York invalidated certain aspects of New York's hospital rate setting scheme on ERISA preemption grounds and expressly stated that it would not follow *Rebaldo.* However, the District Court's decision in that case relied heavily on the decision of the District Court in the within matter, which was subsequently reversed by the Third Circuit. Petitioners also reference the state trial court decision in *United Health Services, Inc. v. Upstate Administrative Services,* 573 N.Y.S. 2d 851 (Sup. Ct. Broome Cty. 1991). The reasoning in *United Health* was based on a flawed premise. The court concluded that plan administrators were subjected to conflicting state regulations by virtue of the challenged statutory provision, since a plan which limited payment to the reimbursement of "actual expenses" would provide a different percentage level of coverage in New York than in a state that did not set reimbursement rates as New York did. This analysis presupposed that hospital rates in all states would have to be set in an identical manner in order to withstand scrutiny under ERISA, and overlooks the fact that things such as wage rates, material costs and the costs of doing business can differ dramatically in different parts of the United States.

Because there is no conflict between the circuits as to the portion of the *Rebaldo* holding relied on by the Third Circuit, and because this portion of the *Rebaldo* court's decision has not been overruled, it is clear that petitioners cannot demonstrate the existence of a conflict between the circuits which would justify the grant of their petition for a Writ of Certiorari.

III.

THE THIRD CIRCUIT'S DISPOSITION OF THE NYSA-ILA WELFARE FUND'S TAKINGS CLAIM IS IN FULL CONFORMITY WITH STANDARDS PREVIOUSLY DELINEATED BY THIS COURT.

Both the District Court and the Court of Appeals concluded that the inclusion of certain costs in the state regulated rates charged by New Jersey hospitals did not deprive petitioners of their property without just compensation in violation of the Fifth Amendment. Petitioner NYSA-ILA Welfare Fund has sought Supreme Court review of the lower courts' disposition of this issue. Since the lower courts decided this issue in conformity with existing Supreme Court precedent, there is no conflict between the Third Circuit's decision and existing decisions of this Court. In addition, there is no Court of Appeals decision which conflicts with the Third Circuit's resolution of this issue, and it does not raise an important question of federal law which has not previously been addressed by this Court. Therefore, no further review by this Court is available.

N.J.S.A. 26:2H-18.d (1992) provided that the reasonable cost of hospital services to indigent patients, as well as bad debts, were to be included as mandatory financial elements of a hospital's preliminary cost base. (Resp. A-20-21). Clearly, the inclusion of such costs in hospital rates does not amount to a physical taking of property. As a result, a less stringent "regulatory takings" analysis, rather than a per se takings analysis, applies to the statutes and regulations being challenged by petitioners. *Concrete Pipe and Products v. Construction Laborers Pension Trust,* 113 S. Ct. 2264, 2290 (1993).

This Court has held that the takings clause is not violated simply because legislation requires one person to use his or her assets for the benefit of another. *Connolly v. Pension Benefit*

Guaranty Corp., 475 U.S. 211, 223 (1986). Moreover, requiring money to be spent in a particular way does not constitute a taking. *See United States v. Sperry Corporation*, 493 U.S. 52 (1989); *Atlas Corp. v. United States*, 895 F.2d 745, 756 (Fed. Cir. 1990), *cert. denied*, 498 U.S. 811 (1990). Evaluation of whether governmental regulation of property constitutes a taking requires an ad hoc factual inquiry into the circumstances of each case. *Connolly*, 475 U.S. at 224. This Court has identified three factors which are to be analyzed in making such a determination. These are: (1) the character of the governmental action; (2) the economic impact of the regulation on the claimant; and (3) the extent to which the regulation has interfered with distinct investment-backed expectations. *Penn Central Transportation Company v. New York City*, 438 U.S. 104, 124 (1978).

The nature of the challenged governmental action here is the inclusion of uncompensated care costs and the costs of the Medicare shortfall and payor differentials in the hospital bills given to all patients. In order to enable hospitals to remain in operation and to provide care to all in need of hospital services, the state reasonably determined that the costs of this care should be spread among all hospital patients. As a result, the Third Circuit concluded that New Jersey's rate system merely "adjusts the benefits and burdens of economic life to promote the common good," a factor which militates against the finding that a taking has occurred. *Concrete Pipe*, 113 S. Ct. at 2290, *quoting Connolly*, 475 U.S. at 225.

Petitioner asserts that a taking occurred because the uncompensated care add-ons paid by ERISA plan participants were paid into a fund managed and controlled by a state bureaucracy. The utilization of this mechanism by the state plainly does not result in the permanent appropriation of private assets. The trust fund mechanism referred to was merely a conduit utilized to fairly distribute collected uncompensated care monies to

hospitals.[12] These monies were not retained by the state. Monies attributable to the Medicare cost shift and payor differentials went directly to hospitals as a component of their hospital rates, and therefore cannot be considered to be appropriated by the state for its own use.

As both the District Court and the Court of Appeals found, plan participants received a clear, specific economic benefit from New Jersey's hospital rate setting system. Therefore, the system's economic impact on them is not so severe as to justify a finding that a taking has occurred. The amount of money paid by plan participants is not determined on an ad hoc basis, since amounts attributable to uncompensated care, the Medicare cost shift and payor differentials were directly related to an individual plan participant's hospital bill. Even in the absence of state regulation of hospital costs, hospitals would have to recoup these costs, because they would go out of business if they failed to do so. By ensuring the recovery of such costs and enabling hospitals to stay in business, New Jersey's hospital rate setting scheme thus protected the interests of ERISA plan participants (and users of hospital services generally) in maintaining access to health care. In addition, to the extent that individual plan participants might not have sufficient assets to pay their full hospital bill, the inclusion of the costs attributable to bad debts within hospital rates would have resulted in coverage of a portion of their bills.

Because hospital rate setting has long been heavily regulated on both the federal and state levels due to its technical complexity, the District Court and Court of Appeals were correct in finding that New Jersey's hospital rate setting statute did not interfere with "reasonable investment-backed expectations." As this Court has

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12. Petitioner's oblique reference to the state's use of the trust fund mechanism as a vehicle for obtaining federal matching funds from the Medicaid program is irrelevant to a takings analysis, as such funds are clearly not private monies.

previously held, reasonable investment-backed expectations under the takings clause must amount to more than a "unilateral expectation." *Webb's Fabulous Pharmacies v. Beckwith*, 449 U.S. 155, 161 (1980).

New Jersey's inclusion of uncompensated care costs and costs attributable to the Medicare cost shift and payor differentials was a long standing feature of New Jersey's state regulated hospital rate setting system. More importantly, as the District Court expressly found, if hospitals established their rates under a free market, competitive system, the challenged components could clearly be included as a portion of the hospital's overall reasonable charge. (Pet. A-92). Given the mechanics of hospital pricing, petitioners cannot reasonably assert that they have a vested right in having the hospital rates they pay exclude such costs.

Since the Third Circuit's decision conforms with prior decisions of this Court as to petitioner's takings claims, there is no valid reason for this Court to revisit the conclusions reached by the lower courts as to these claims.

IV.

THIS CASE DOES NOT PRESENT AN IMPORTANT QUESTION OF FEDERAL LAW WHICH SHOULD BE SETTLED BY THIS COURT.

Petitioners urge the Court to grant their Petitions because of the current national interest in health care reform. They also contend that the Court needs to review this case because of pending legislative initiatives in a number of states concerning hospital rate setting.

No matter how much interest may be engendered by health care issues at the moment, these circumstances clearly do not

warrant this Court's review. First of all, this case does not present a novel issue that has not previously been addressed by the Supreme Court. While the specific, narrow issue of ERISA preemption in the context of hospital rate setting has not been addressed, this Court has had occasion to review the general question of whether a state statute should be found preempted by ERISA numerous times. In deciding these cases, the Court has fashioned a test which requires that the state statute must impact upon the ERISA plan, rather than plan participants or plan benefits, in order for it to be found preempted. All that the Third Circuit did was to apply the analysis previously reached by the Court in these cases in concluding that New Jersey's hospital rate setting statute did not impact upon the plan in a manner which would require preemption.

The significance of the Third Circuit's decision has largely been eclipsed by subsequent developments in New Jersey. The State of New Jersey deregulated hospital rate setting effective January 1, 1993. *L.* 1992, c. 160. As a result, any decision the Court might reach would have no impact whatsoever on the establishment of hospital rates in New Jersey, since that function is no longer state regulated. The only remaining "live" issue between the parties relates to the question of whether plans should have to pay the full DRG rate for services rendered during the period that this litigation was ongoing. While final resolution of this issue might be important to the individual parties from a financial perspective, it clearly does not present the Court with an ongoing issue of such national importance that review by this Court is warranted.

Finally, the fact that there are pending legislative initiatives with respect to the issue of hospital rate setting in a number of states does not warrant further review by this Court. While health care reform may indeed be a pressing national issue, this court is not in the business of rendering advisory opinions. Yet this is tantamount to what petitioners are seeking when they requested review of this case because of pending state legislative initiatives.

Given the large number of federal court decisions in existence where an ERISA preemption claim was addressed, it is more than likely that this Court will have the opportunity to revisit the limits of its prior preemption decisions again in the future. Accordingly, this is not a case which presents a special or novel issue that would warrant Supreme Court review.

CONCLUSION

Because petitioners have failed to establish that they meet the requirements for the grant of a Petition for a Writ of Certiorari, it is respectfully requested that the Court deny the Petitions for a Writ of Certiorari.

Respectfully submitted,

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APPENDIX A — CORPORATE DESIGNATION OF RESPONDENTS

In accordance with Rule 29.1, respondents state that they have the following corporate parent-subsidiary relationships:

1. Atlantic City Medical Center; No parent or subsidiaries.

2. Nathan and Miriam Barnert Memorial Hospital d/b/a Barnert Hospital; No parent or subsidiaries.

3. Bayonne Hospital; No parent or subsidiaries.

4. Bayshore Community Hospital; Parent - Bayshore Health Care Services, Inc.; No subsidiaries.

5. Burdette Tomlin Memorial Hospital; Parent - Cape Health System, Inc.; No subsidiaries.

6. Chilton Memorial Hospital; Parent - Memorial Health Foundation (formerly known as Chilton Memorial Corporation); No subsidiaries.

7. Christ Hospital; Parent - Christ Hospital Health Services Corporation; No subsidiaries.

8. Clara Maass Medical Center; Parent - Clara Maass Health Systems, Inc.; No subsidiaries.

9. Community Medical Center; Parent - Community Memorial Health Services; No subsidiaries.

10. Cooper Hospital/University Medical Center; Parent - Cooper Health Care; No subsidiaries.

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11. Deborah Heart and Lung Center; No parent or subsidiaries.

12. Dover General Hospital & Medical Center; Parent - Lake Area Health System; No subsidiaries.

13. East Orange General Hospital; Parent - Essex Valley Health Care; No subsidiaries.

14. Englewood Hospital and Medical Center; Parent - Englewood Health Care Foundation, Inc.; No subsidiaries.

15. Hackensack Medical Center; Parent - Hillcrest Health Service System, Inc.; No subsidiaries.

16. Hackettstown Community Hospital; No parent or subsidiaries.

17. Helene Fuld Medical Center; Parent - Helene Fuld Healthcare; No subsidiaries.

18. Holy Name Hospital; No parent or subsidiaries.

19. Hunterdon Medical Center; Parent - Hunterdon Healthcare System, Inc.; No subsidiaries.

20. Irvington General Hospital; Parent - Beth Health Care Services Corporation; No subsidiaries.

21. Jersey Shore Medical Center; Parent - Modern Health Affiliates, Inc.; No subsidiaries.

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22. Community Hospital Group, Inc. d/b/a The JFK Medical Center; Parent - JFK Health Systems; No subsidiaries.

23. Kennedy Memorial Hospitals-University Medical Center; Parent - Kennedy Health Care Foundation; No subsidiaries.

24. William B. Kessler Memorial Hospital; No parent or subsidiaries.

25. Kimball Medical Center; Parent - Kimball Health Care Corporation; No subsidiaries.

26. The Medical Center of Ocean County, Inc.; Parent - The Ocean Health System, Inc.; No subsidiaries.

27. The Mercer Medical Center; No parent or subsidiaries.

28. Memorial Hospital of Burlington County; Parent - Memorial Health Alliance, Inc.; Subsidiary - Women's Auxiliary Board to Memorial Hospital of Burlington County.

29. Monmouth Medical Center; Parent - Mid-Atlantic Health Group, Inc.; No subsidiaries.

30. Morristown Memorial Hospital; Parent - Memorial Health Foundation, Inc.; No subsidiaries.

31. The Mountainside Hospital; Parent - Mountainside Hospital Healthcare, Inc.; No subsidiaries.

32. Muhlenberg Regional Medical Center; Parent - The Huntington Foundation; Subsidiaries - Muhlenberg Auxiliary, Inc.; and Muhlenberg Foundation, Inc.

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33. Newark Beth Israel Medical Center; Parent - Beth Health Care Services Corporation; No subsidiaries.

34. New Jersey Hospital Association; No parent or subsidiaries.

35. Newton Memorial Hospital; Parent - North Jersey Health Care Corp.; No subsidiaries.

36. The Hospital Center at Orange; No Parent; Subsidiaries - HCO Plus; Meals on Wheels; Orange Mountain Health Care; OMH Services; Zorah; and 323 Central Avenue.

37. Our Lady of Lourdes Medical Center; Parent - Our Lady of Lourdes Health Care Services, Inc.; Subsidiaries - Osborne Family Health Center, Inc.; and Our Lady of Lourdes School of Nursing.

38. Overlook Hospital; No parent or subsidiaries.

39. Palisades General Hospital; No parent or subsidiaries.

40. Pascack Valley Hospital; Parent - Well Care Group, Inc.; No subsidiaries.

41. The General Hospital Center of Passaic; Parent - Healthcare Continuum, Inc.; No subsidiaries.

42. The Medical Center at Princeton; No parent or subsidiaries.

43. Rahway Hospital; Parent - Recovery Healthsystems, Inc.; No subsidiaries.

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44. Raritan Bay Medical Center; Parent - Raritan Bay Health Service Corporation; No subsidiaries.

45. Riverview Medical Center; Parent - Riverview Health Care

46. Robert Wood Johnson University Hospital; Parent - RWJ Healthcare Corporation; No subsidiaries.

47. Kennedy Memorial Hospitals at Saddle Brook, Inc.; Parent - Kessler Rehabilitation Corporation; No subsidiaries.

48. Shore Memorial Hospital; Parent - Shore Memorial Health Foundation, Inc.; No subsidiaries.

49. Somerset Medical Center; Parent - Somerset Health Care Corporation; No subsidiaries.

50. South Amboy Memorial Hospital; Parent - South Amboy Memorial Hospital Association; No subsidiaries.

51. South Jersey Hospital System; Parent - Cooperative Health Care of Southern New Jersey, Inc.; Subsidiary - Community Health Care, Inc.

52. St. Barnabas Medical Center; Parent - St. Barnabas Corporation; No subsidiaries.

53. St. Clare's/Riverside Medical Center; Parent - SSM Healthcare Ministry Corporation; No subsidiaries.

54. St. Elizabeth Hospital; No parent or subsidiaries.

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55. St. Francis Hospital; Parent - Franciscan Health System of New Jersey, Inc.; No subsidiaries.

56. St. James Hospital; Parent - Cathedral Health Services, Inc.; No subsidiaries.

57. St. Joseph's Hospital & Medical Center; No parent or subsidiaries.

58. St. Mary Hospital; Parent - Franciscan Health System of New Jersey, Inc.; No subsidiaries.

59. St. Michael's Medical Center; Parent - Cathedral Health Services, Inc.; No subsidiaries.

60. St. Peter's Medical Center; No parent or subsidiaries.

61. Union Hospital; Parent - Mega Source, Inc.; No subsidiaries.

62. United Hospitals Medical Center; No parent or subsidiaries.

63. Underwood-Memorial Hospital; Parent - Underwood-Memorial Health Systems, Inc.; No subsidiaries.

64. The Valley Hospital; Parent - Valley Care Corp.; Subsidiary - Valley Health Services, Inc.

65. Wallkill Valley Hospital & Health Centers; Parent - Sisters of Sorrowful Mothers; No subsidiaries.

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66. Warren Hospital; Parent - Warren Hospital Health Services Corporation; No subsidiaries.

67. Wayne General Hospital; Parent - North Jersey Meditech; No subsidiaries.

68. West Hudson Hospital; Parent - Trico Health Care, Inc.; No subsidiaries.

69. West Jersey Hospital; Parent - West Jersey Health System; No subsidiaries.

70. Zurbrugg Memorial Hospital; Parent - Zurbrugg Health Foundation; No subsidiaries.

APPENDIX B — STATUTES REFERENCED

N.J.S.A. 26:2H-1

26:2H-1. Declaration of policy

It is hereby declared to be the public policy of the State that hospital and related health care services of the highest quality, of demonstrated need, efficiently provided and properly utilized at a reasonable cost are of vital concern to the public health. In order to provide for the protection and promotion of the health of the inhabitants of the State, promote the financial solvency of hospitals and similar health care facilities and contain the rising cost of health care services, the State Department of Health, which has been designated as the sole agency in this State for comprehensive health planning under the "National Health Planning and Resources Development Act of 1974" (Federal Law 93-641),[1] as amended and supplemented, shall have the central, comprehensive responsibility for the development and administration of the State's policy with respect to health planning, hospital and related health care services and health care facility cost containment programs, and all public and private institutions, whether State, county, municipal, incorporated or not incorporated serving principally as residential health care facilities, nursing or maternity homes or as facilities for the prevention, diagnosis, or treatment of human disease, pain, injury, deformity or physical condition, shall be subject to the provisions of this act.

N.J.S.A. 26:2H-2

26:2H-2. Definitions

The following words or phrases, as used in this act, shall have the following meanings, unless the context otherwise requires:

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1. 42 U.S.C.A. § 300k et seq.

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a. "Health care facility" means the facility or institution whether public or private, engaged principally in providing services for health maintenance organizations, diagnosis of treatment of human disease, pain, injury, deformity or physical condition, including, but not limited to, a general hospital, special hospital, mental hospital, public health center, diagnostic center, treatment center, rehabilitation center, extended care facility, skilled nursing home, nursing home, intermediate care facility, tuberculosis hospital, chronic disease hospital, maternity hospital, outpatient clinic, dispensary, home health care agency, residential health care facility and bioanalytical laboratory (except as specifically excluded hereunder) or central services facility serving one or more such institutions but excluding institutions that provide healing solely by prayer and excluding such bioanalytical laboratories as are independently owned and operated, and are not owned, operated, managed or controlled, in whole or in part, directly or indirectly by any one or more health care facilities, and the predominant source of business of which is not by contract with health care facilities within the State of New Jersey and which solicit or accept specimens and operate predominantly in interstate commerce.

b. "Health care service" means the preadmission, outpatient, inpatient and postdischarge care provided in or by a health care facility, and such other items or services as are necessary for such care, which are provided by or under the supervision of a physician for the purpose of health maintenance organizations, diagnosis or treatment of human disease, pain, injury, disability, deformity or physical condition, including, but not limited to, nursing service, home care nursing and other paramedical service, ambulance service, service provided by an intern, resident in training or physician whose compensation is provided through agreement with a health care facility, laboratory service, medical social

service, drugs, biologicals, supplies, appliances, equipment, bed and board, but excluding services provided by a physician in his private practice or by practitioners of healing solely by prayer, and services provided first aid rescue and ambulance squads as defined in the "New Jersey Safety Highway Act of 1971," P.L. 1971, c. 351 (C. 27:5F-1 et seq.).

c. "Construction" means the erection, building, or substantial acquisition, alteration, reconstruction, improvement, renovation, extension or modification of a health care facility, including its equipment, the inspection and supervision thereof; and the studies, surveys, designs, plans, working drawings, specifications, procedures, and other actions necessary thereto.

d. "Board" means the Health Care Administration Board established pursuant to this act.

e. "Commission" means the Hospital Rate Setting Commission established pursuant to this act.

f. "Government agency" means a department, board, bureau, division, office, agency, public benefit or other corporation, or any other unit, however described, of the State or political subdivision thereof.

g. "Statewide Health Coordinating Council" means the Statewide Health Coordinating Council formed under the provisions of Federal Law 93-641, as amended and supplemented.[1]

h. "Health Systems Agency" means an officially recognized health systems agency formed under the provisions of Federal law 93-641 as amended and supplemented.[2]

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1. 42 U.S.C. A. § 300k et seq.

2. 42 U.S.C.A. § 300*l*-1

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i. "Department" means the State Department of Health.

j. "Commissioner" means the State Commissioner of Health.

k. "Preliminary cost base" means that proportion of a hospital's current cost which may reasonably be required to be reimbursed to a properly utilized hospital for the efficient and effective delivery of appropriate and necessary health care services of high quality required by such hospital's mix of patients. The preliminary cost base initially may include costs identified by the commissioner and approved or adjusted by the commission as being in excess of that proportion of a hospital's current costs identified above, which excess costs shall be eliminated in a timely and reasonable manner prior to certification of the revenue base. The preliminary cost base shall be established in accordance with regulations proposed by the commissioner and approved by the board.

l. "Certified revenue base" means the preliminary cost base adjusted by the commission, as appropriate and necessary pursuant to regulations proposed by the commissioner and approved by the board, to provide for the financial solvency of a hospital which is properly utilized and which delivers, effectively and efficiently, appropriate and necessary health care services of a high quality required by its mix of patients.

m. "Provider of health care" means an individual (1) who is a direct provided of health care service in that the individual's primary activity is the provision of health care services to individuals or the administration of health care facilities in which such care is provided and, when required by State law, the individual has received professional training in the provision of such services or in such administration and is licensed or certified

for such provision or administration; or (2) who is an indirect provider of health care in that the individual (a) holds a fiduciary position with, or has a fiduciary interest in, any entity described in subparagraph b(ii) or subparagraph b(iv); provided, however, that a member of the governing body of a county or any elected official shall not be deemed to be a provider of health care unless he is a member of the board of trustees of a health care facility or a member of a board, committee or body with authority similar to that of a board of trustees, or unless he participates in the direct administration of a health care facility; or (b) received, either directly or through his spouse, more than one-tenth of his gross annual income for any one or more of the following:

(i) Fees or other compensation for research into or instruction in the provision of health care services;

(ii) Entities engaged in the provision of health care services or in research or instruction in the provision of health care services;

(iii) Producing or supplying drugs or other articles for individuals or entities for use in the provision of or in research into or instruction in the provision of health care services;

(iv) Entities engaged in producing drugs or such other articles.

n. "Private long-term health care facility" means a nursing home, skilled nursing home or intermediate care facility presently in operation and licensed as such prior to the adoption of the 1967 Life Safety Code by the State Department of Health in 1972 and which has a maximum 50-bed capacity and which does not accommodate Medicare or Medicaid patients.

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N.J.S.A. 26:2H-4.1

26:2H-4.1. Hospital rate setting commission

a. There is hereby established in the State Department of Health a Hospital Rate Setting Commission which shall consist of five members, three of whom shall be appointed by the Governor with the advice and consent of the Senate for terms of 4 years. Of the initial appointees, one shall serve for a term of 2 years and one for a term of 3 years. No member shall be eligible for appointment for more than two full consecutive terms. Two of the members appointed by the Governor shall be consumers of health care services who are not providers of health care services, and one shall have experience in hospital administration or finance. The Commissioners of the State Departments of Health and Insurance or their designated representatives, who shall be officials with the rank of deputy or assistant commissioner, shall serve as ex-officio voting members of the commission. The commission shall annually select a chairman from among its members. Three members of the commission shall constitute a quorum and no action of the commission shall be taken except upon the affirmative vote of a majority of its members.

The appointed members of the commission shall each receive compensation at $150.00 per day. The commission members shall also be entitled to reasonable expenses incurred in the performance of their duties. Any such member may be removed from office by the Governor, for good cause shown. Any vacancy occurring in the membership of the commission for any cause shall be filled in the same manner as the original appointment but for the unexpired term only. A member shall otherwise continue to serve after expiration of his term until a new appointment is made.

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The commission shall select an executive secretary and the commissioner shall provide to the commission such clerical staff, supplies and equipment as may be necessary for it to faithfully discharge its duties.

The commission shall be established and its members appointed by January 1, 1979.

b. The commissioner shall determine the order in which hospitals shall have their preliminary cost base and appropriate schedule of rates approved by the commission. The commissioner shall propose and the commission approve or adjust the preliminary cost base, and the commission shall approve an appropriate schedule of rates for all hospitals by January 1, 1983. The schedule of rates shall be reasonable and sufficient to provide the revenue requirements of the preliminary cost base and shall be adjusted from time to time, as appropriate, to reach the certified revenue base.

The commission shall certify the revenue base, provided the conditions described in subsections k. and *l.* of section 2 of this act has been met, and shall perform such other duties as are specified elsewhere in this act.

A hospital shall continue to be reimbursed under the rate setting system in effect on the day preceding the effective date of this act, except as said system is amended by regulation, until the commission approves the hospital's preliminary cost base.

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N.J.S.A. 26:2H-5

26:2H-5. Powers of commissioner

a. The commissioner, to effectuate the provisions and purposes of this act, shall have the power to inquire into health care services and the operation of health care facilities and to conduct periodic inspections of such facilities with respect to the fitness and adequacy of the premises, equipment, personnel, rules and bylaws and the adequacy of financial resources and sources of future revenues.

b. The commissioner, with the approval of the board, shall adopt and amend rules and regulations in accordance with the Administrative Procedure Act, P.L. 1968, c. 410 (C. 52:14B-1 et seq.) to effectuate the provisions and purposes of this act, including but not limited to: (1) the establishment of requirements for a uniform Statewide system of reports and audit relating to the quality of health care provided, health care facility utilization and costs; (2) certification by the department of schedules of rates, payments, reimbursement, grants and other charges for health care services as provided in section 18; and (3) standards and procedures relating to the licensing of health care facilities and the institution of additional health care services.

c. The commissioner may enter into contracts with any government agency, institution of higher learning, voluntary nonprofit agency, or appropriate planning agency or council; and such entities are authorized to enter into contracts with the commissioner to effectuate the provisions and purposes of this art.

d. The commissioner may provide consultation and assistance to health care facilities in operational techniques,

including but not limited to, planning, principles of management, and standards of health care services.

e. At the request of the commissioner, health care facilities shall furnish to the Department of Health such reports and information as it may require to effectuate the provisions and purposes of this act, excluding confidential communications from patients.

f. The commissioner may institute or cause to be instituted in a court of competent jurisdiction proceedings to compel compliance with the provisions of this act or the determinations, rules, regulations and orders of the commissioner.

g. Notwithstanding any rules and regulations governing private long-term health care facilities and enforcing the 1967 Life Safety Code, as amended and supplemented, the commissioner shall permit third floor occupancy of such facilities by owners, members of their immediate families, and licensed professionals employed at such facilities.

N.J.S.A. 26:2H-12

26:2H-12. Health care facility; requirements for operation; license; application; fees; issuance; renewals

a. No health care facility shall be operated unless it shall: (1) possess a valid license issued pursuant to this act, which license shall specify the kind or kinds of health care services the facility is authorized to provide; (2) establish and maintain a uniform system of cost accounting approved by the commissioner; (3) establish and maintain a uniform system of reports and audits meeting the requirements of the commissioner; (4) prepare and review

annually a long range plan for the provision of health care services, which plan shall be compatible with the State Health Plan established pursuant to the "National Health Planning and Resources Development Act of 1974" (Federal Law 93-641)[1] as related to medical health services, health care services, and health manpower; and (5) establish and maintain a centralized, coordinated system of discharge planning which assures every patient a planned program of continuing care and which meets the requirements of the commissioner which requirements shall, where feasible, equal or exceed those standards and regulations established by the Federal Government for all federally-funded health care facilities but shall not require any person who is not in receipt of State or Federal assistance to be discharged against his will.

b. (1) Application for a license for a health care facility shall be made upon forms prescribed by the department. The department shall charge such nonrefundable fees for the filing of an application for a license and any renewal thereof, as it shall from time to time fix in rules or regulations; provided, however, that no such fee shall exceed $2,000.00. The application shall contain the name of the health care facility, the kind or kinds of health care service to be provided, the location and physical description of the institution, and such other information as the department may require. (2) A license shall be issued by the department upon its findings that the premises, equipment, personnel, including principals and management, finances, rules and bylaws, and standards of health care service are fit and adequate and there is reasonable assurance the health care facility will be operated in the manner required by this act and rules and regulations thereunder.

---

1. 42 U.S.C.A. § 300K et seq.

c. A license issued before the effective date of this act to a health care facility for its operation, upon the first renewal date thereafter, may be extended for a 1 year period of time, provided the facility then meets the requirements for licensure at the time said license was issued and submits an acceptable plan to meet current requirements at the end of said period of time.

N.J.S.A. 26:2H-18

26:2H-18. Payments by government agency or hospital service corporation; determination of rates

a. No government agency and no hospital service corporation organized under the laws of the State and no other purchasers of health care services shall purchase, pay for or make reimbursement or grant-in-aid for any health care service provided by a health care facility unless at the time the service was provided, the health care facility possessed a valid license or was otherwise authorized to provide such service.

b. Payment by government agencies other than those made through the Medical Assistance and Health Services Act, P.L. 1968, c. 413 (C. 30:4D-1 et seq.), and payment by hospital service corporations organized under the laws of this State for health care services provided by a hospital shall be at reasonable rates approved by the commission as provided for by regulations proposed by the commissioner and approved by the board.

The schedule of rates shall be reasonable and sufficient to provide the revenue requirements of the certified revenue base of a hospital, considering the health care system as a whole and based on financial elements approved by the commissioner. Nothing herein shall be construed to prohibit the Commissioner of Human

Appendix B

Services from contracting with the Commissioner of Health for the commission to approve rates, on behalf of the Commissioner of Health, by which hospitals are reimbursed pursuant to the Medical Assistance and Health Services Act, P.L. 1968, c. 413 (C. 30:4D-1 et seq.). Rates of payment by hospital service corporations organized under the law of this State for health care services provided by a hospital shall be set by the commission. Payment by all other purchasers of health care services provided by a hospital shall be at reasonable rates approved by the commission as provided in this act. All payment rates shall be equitable for each payor or class of payors without discrimination or individual preference except for quantifiable economic benefits rendered to the institution or to the health care delivery system taken as a whole. In addition to other such benefits which the commission may consider, it shall consider the following, if found to be quantifiable: (1) degree of promptness and volume of payments to hospitals so that hospitals are provided with funds for current financing of their services; and (2) broad provision of health insurance coverages which are not otherwise affordable or obtainable at premium rates which are not self-supporting. In determining the quantifiable economic benefits to which consideration shall be given in approving payment rates, the commission may consider overall financial benefits to society which are provided by programs offered by a payor or class of payors.

c. Payment by government agencies other than those made through the Medical Assistance and Health Services Act, P.L. 1968, c. 413 (C. 30:4D-1 et seq.), and payment by hospital service corporations organized under the laws of this State for health services provided by health care facilities other than hospitals shall be at reasonable rates set by the commissioner based on financial elements approved by him; provided, however, that nothing herein

shall be construed to prohibit the Commissioner of Human Services from contracting with the commissioner for the setting of rates by which health care facilities other than hospitals are reimbursed pursuant to the Medical Assistance and Health Services Act, P.L. 1968, c. 413 (C. 30:4D-1 et seq.). Rates of payment by hospital service corporations organized under the laws of this State for health care services provided by a health care facility other than hospitals shall be set in consultation with the Commissioner of Insurance.

d. The financial elements of the preliminary cost base and of the certified revenue base shall include the reasonable cost of the following, as defined in regulations proposed by the commissioner and approved by the board: direct patient care; principal and interest payments; paid taxes, excluding income taxes; educational, research and training programs, not otherwise paid for by the State; the provision of health care services to individuals unable to pay for them for reasons of indigency; bad debts, provided adequate recovery procedures are followed; preservation, replacement and improvement of facility and equipment subject to appropriate planning requirements; and reasonable working capital. Said financial elements may include, where applicable and appropriate, a reasonable return on investment where a hospital is operating efficiently and effectively. In determining proposed payments to hospitals, the commissioner shall take into account a facility's income from all sources, including specific purpose grants and other funds from governmental sources, but excluding income and principal from board or donor restricted funds, gifts and special fund raising projects.

To establish and maintain a fair and equitable system for determining such payments, the commissioner shall require each

health care facility to report such financial, statistical and patient information as may be required, in accordance with a uniform system of reporting established by him. The commissioner may propose regulations for approval by the board which assess penalties for failure to report such information within such time as may be prescribed therein.

N.J.S.A. 26:2H-18.1

26:2H-18.1. Preliminary cost base, certified revenue base or schedule of rates; adjustments; determination and review by commission; regulations

a. The commission shall make the determinations and hear appeals provided for in this act in a timely manner pursuant to regulations proposed by the commissioner and approved by the board. Such regulations shall be presented to the Standing Legislative Committees on Institutions, Health and Welfare for final approval within 1 year following establishment of the commission pursuant to the provisions of this act, and shall remain in effect in the form proposed by the commissioner and approved by the board until the provisions of such regulations are enacted into law as amendments to this act. Such regulations shall require that in the event the commission does not perform its duties within the time period specified therein the commission may permit a hospital to make a temporary reasonable change in rates which shall be effective immediately, when it deems it in the public interest to do so. Notwithstanding such temporary change in rates, the review procedure set forth in this section shall be conducted by the commission as soon thereafter as is possible.

b. Pursuant to regulations proposed by the commissioner and approved by the board, the commissioner shall propose and the

commission shall make automatic periodic adjustments to each preliminary cost base or certified revenue base for changes in economic factors reasonably calculated to provide for the effects of general economic inflation or deflation; for industry wide changes in the efficiency of delivering health care services; and for each hospital's actual changes in volume and case-mix, which are necessary and appropriate. The commission shall approve an appropriate change in the schedule of rates to reflect these adjustments.

c. Pursuant to regulations proposed by the commissioner and approved by the board, the commission shall consider adjustments to the certified revenue bases and schedules of rates, provided such adjustments: (1) result from statutes and regulations affecting the delivery of health care; and (2) may affect one or more hospitals. Such adjustments shall take into account the effectiveness and efficiency of the health care delivery system as a whole. Where appropriate the commission may sit en banc and hold public hearings in order to obtain the evidence required to support its conclusions and determinations. In the case of such hearings the commission shall provide actual notice to the affected planning and licensing authorities and hospitals, and to the commissioner and the Public Advocate.

d. Pursuant to regulations proposed by the commissioner and approved by the board, all other changes in the commission's determinations shall require a review by the commission in a public hearing of the entire preliminary cost base or certified revenue base and schedule of rates. Determinations of the commission may be appealed by hospitals, the commissioner, the Public Advocate, affected planning, licensing or inspection agencies and payors, and other affected parties, and shall be conducted as contested proceedings under the Administrative

Procedures Act, P.L. 1968, c. 410 (C. 52:14B-1 et seq.). During the pendency of any appeal, the schedule of rates approved by the commission pursuant to sections 5 and 10 of this act[1] shall remain in effect.

In all appeals, the burden of proof shall be on the petitioner. All determinations rendered hereunder shall be consistent with regulations and shall set forth in detail the commission's reasoning and conclusions regarding the parties and considerations specified in this act.

P.L. 1971, c. 136, § 18

* * *

18.

a. No government agency and no hospital service corporation organized under the laws of the State shall purchase, pay for or make reimbursement or grant-in-aid for any health care service provided by a health care facility unless at the time the service was provided, the health care facility possessed a valid license or was otherwise authorized to provide such service.

b. Payment by government agencies for health care services provided by a health care facility shall be at rates established by the commissioner, based on elements of costs approved by him.

c. The Commissioner of Health in consultation with the Commissioner of Insurance shall determine and certify the costs of providing health care services, as reported by health care facilities, which are derived in accordance with a uniform system of cost

1. Sections 26:2H-4.1, 26:2H-18.

accounting approved by the Commissioner of Health. Said certification shall specify the elements and details of costs taken into consideration.

d. Payment by hospital service corporations, organized under the laws of this State, for health care services provided by a health care facility shall be at rates approved as to reasonableness by the Commissioner of Insurance with the approval of the Commissioner of Health. In establishing such rates, the commissioners shall take into consideration the total costs of the health care facility.

P.L. 1991, c. 187, § 1

CHAPTER 187

1.[1] (New section) The Legislature finds and declares that:

a. Access to quality health care shall not be denied to residents of the State because of their inability to pay for the care; there are many residents of the State, particularly those with incomes below the federal poverty level, who cannot pay for needed hospital care and in order to ensure that these persons have equal access to hospital care it is necessary to maintain a mechanism which will ensure payment of uncompensated hospital care; and to protect the fiscal solvency of the State's general hospitals, as provided for in P.L. 1971, c. 136 (C. 26:2H-1 et al.), it is necessary that all payers of health care services share equally in the payment of uncompensated care on a Statewide basis.

b. The "New Jersey Uncompensated Care Trust Fund," created pursuant to P.L. 1986, c. 204, and continued pursuant to

1. N.J.S.A. 26:2H-18.24.

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P.L. 1989, c. 1 (C. 26:2H-18.4 et seq.), which law expired on December 31, 1990, by which hospitals were able to collect their reasonable cost of approved uncompensated care, resulted in unobstructed access to health care for reidents without insurance who otherwise are unable to afford care.

c. Having received and thoroughly reviewed the reports issued by the Commissioner of Health and the Governor's Commission on Health Care Costs on uncompensated care, its economic implications and various means of financing uncompensated care, it is evident that provision for a trust fund is necessary, with modifications, to ensure access to hospital care for those who cannot afford to pay and the fiscal solvency of hospitals. At the same time, the State should take further actions to: provide more comprehensive Medicaid coverage for the medically indigent, reduce the rate of increase in health insurance premiums and explore and implement various initiatives to reduce the amount of uncompensated care in this State without impairing access to care.

Supreme Court, U.S.
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Nos. 93-115, 93-193, 93-194, 93-210

In The

Supreme Court of the United States

October Term, 1993

NYSA-ILA WELFARE FUND, et al.,

Petitioners,

v.

FRANCES J. DUNSTON, in her capacity as NEW JERSEY COMMISSIONER OF HEALTH, et al.,

Respondents.

On Petition For Writ Of Certiorari To The United States Court Of Appeals For The Third Circuit*

RESPONDENTS' BRIEF AND APPENDIX IN OPPOSITION TO PETITIONS FOR A WRIT OF CERTIORARI

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NEW JERSEY CARPENTERS WELFARE FUND, et al.,

Petitioners,

v.

FRANCES J. DUNSTON, in her capacity as
NEW JERSEY COMMISSIONER OF HEALTH, et al.,

Respondents.

TRUSTEES OF THE WELFARE TRUST FUND,
LOCAL UNION NO. 475, et al.,

Petitioners,

v.

FRANCES J. DUNSTON, in her capacity as
NEW JERSEY COMMISSIONER OF HEALTH, et al.,

Respondents.

UNITED WIRE, METAL & MACHINE HEALTH
AND WELFARE FUND, et al.,

Petitioners,

v.

MORRISTOWN MEMORIAL HOSPITAL, et al.,

Respondents.

QUESTIONS PRESENTED

1. Did New Jersey's now-repealed system of hospital rate regulation "relate to" employee benefit plans within the meaning of section 514(a) of the Employee Retirement Income Security Act ("ERISA"), 29 U.S.C. § 1144(a)? More generally stated, does a state regulatory system that sets the price of hospital care for patients but that does not impose any coverage or reimbursement obligations on third-party payors "relate to" employee benefit plans?

2. Does a state system of hospital rate regulation that folds into the rate structure costs arising from the provision of hospital care to non-paying or underpaying patients result in a compensable "taking" of employee benefit plan property?

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STATEMENT OF THE CASE

I. New Jersey's Former Rate System.

In 1978, the New Jersey Legislature enacted a system of hospital rate regulation to "promote the financial solvency of hospitals . . . and contain the rising costs of health care services." N.J. Stat. Ann. ("N.J.S.A.") 26:2H-1 (amended 1992).* Under this system, the many types of medical procedures performed at hospitals were divided into "diagnostic related groups" ("DRGs"), and a rate assigned to each DRG. The system was designed to penalize hospitals that incurred costs greater than the DRG rate and to reward more efficient hospitals, thereby providing hospitals with an incentive to keep costs down. *See, e.g.*, N.J. Admin. Code ("N.J.A.C.") 8:31B-3.5.

Like most if not all regulatory rate systems, New Jersey's former hospital rate system operated on the premise that the rates should allow efficient members of the regulated industry to recover their reasonable costs of doing business. N.J.A.C. 8:31B-1.1. One cost of doing business as a hospital is the cost of providing care to patients who are unable to pay their bills, a cost known as "uncompensated care." In all states, hospitals incur substantial uncompensated care costs, both because federal law requires hospitals to treat emergency patients regardless of ability to pay, *see* 42 U.S.C. § 1395dd, and because many hospitals, under their internal by-laws and operating procedures, impose similar requirements on themselves. In New Jersey, state law requires all hospitals to

*The New Jersey Statutes referenced herein are reproduced in the Appendix to the Brief in Opposition on behalf of respondent New Jersey Hospital Association.

accept and treat patients regardless of ability to pay. *See* N.J.S.A. 26:2H-18.64; N.J.A.C. 8:43G-5.2(c).

Under the rate system as originally enacted, uncompensated care costs incurred by a particular hospital were borne only by that hospital's patients. Each hospital, therefore, included in its rates a hospital-specific charge for uncompensated care in order to recover its costs in this area. Over time, hospitals providing large amounts of uncompensated care – primarily hospitals located in the state's urban areas – were thus forced to charge higher rates than other hospitals. The resultant disparity in rates threatened the financial viability of New Jersey's inner-city hospitals.

In response to this problem, and to avoid the prospect of large urban areas and populations with no accessible hospital care, New Jersey amended its rate-setting system in 1987 to provide that all hospitals in the state would share equally in the cost of uncompensated care. Under this amendment, all hospital bills were required to include a uniform uncompensated care charge, set annually by the State's Hospital Rate-Setting Commission at a level intended to generate revenues approximating statewide uncompensated care costs. N.J.S.A. 26:2H-18(d) (repealed 1992). The charges collected from all patients and hospitals across the state were then pooled into a fund known as the New Jersey Health Care Trust Fund, and ultimately redistributed back to hospitals according to the amount of uncompensated care provided by them.

Another cost of doing business as a hospital (in some respects a variant of uncompensated care) is the cost of treating patients eligible for Medicare. Under federal law,

hospitals can charge such patients only the amount Medicare pays for the particular treatment. From 1980-1988, the Medicare program participated fully in New Jersey's rate system and accepted the rates established by it. In 1989, however, Medicare began paying hospitals in New Jersey at rates below the state-regulated rate – and, as has been widely acknowledged, below any reasonable measure of the cost of providing care. To enable hospitals to make up for the resultant shortfall in revenues, the state-regulated rate had to be adjusted, and a charge included in all hospital bills to make up for Medicare's below-cost reimbursement rates. *See* N.J.S.A. 26:2H-18(c) (repealed 1992). This charge came to be known, in New Jersey as elsewhere, as the "Medicare cost-shift." *See generally,* Congressional Report C-92-03, "Optional Hospital Payment Rates for Private Payers Based on Medicare's Methods" (March 1992) (detailing the prevalence throughout the United States of Medicare cost-shifts by hospitals).

Another charge built into hospital rates under New Jersey's former rate system related to "payor differentials." Under the operative rate statutes, and in keeping with their underlying purpose of cost-containment, the Hospital Rate Setting Commission was authorized to grant a "differential" (*i.e.,* price discount) to payors providing "quantifiable economic benefits . . . to the health care delivery system taken as a whole." *See* N.J.S.A. 26:2H-18(b) (repealed 1992). Under this provision, differentials were provided to "open enrollment" programs such as Blue Cross/Blue Shield because, by offering open enrollment, such programs reduced (or at least helped to contain) the number of uninsured patients – and, hence,

to contain the uncompensated care costs incurred by hospitals. Blue Cross receives a similar discount in many states. *See generally,* P. Ginsburg, "Hospital Cost Shifting," 310 New England Journal of Medicine 893 (April 1984). Payor differentials were also granted to health maintenance organizations ("HMOs") able to show the achievement of economic benefits through their efforts at "managed care." Hospital patients covered by Blue Cross or HMOs would thus be charged at a discounted rate, and patients not covered by such plans would be charged at a correspondingly higher rate.

New Jersey's former rate system did not dictate that third-party payors cover or be responsible for paying any amount, percentage or portion of hospital bills. Rather, it set the price of hospital care *for patients* in New Jersey. Third-party payors like the petitioning employee benefit plans were, as both a legal and practical matter, free to determine for themselves how much coverage they would provide for their plan members.*

Under the rate system, hospital costs in New Jersey rose steadily, as they did throughout the country during that time period (1978-1993). Data compiled by the American Hospital Association showed, however, that hospital rates in New Jersey during the period of rate regulation were generally lower than in neighboring states. From the

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*This feature of New Jersey's former rate system distinguishes it from the statutory scheme at issue in *Bricklayers Local No. 1 Welfare Fund v. Louisiana Health Ins. Ass'n,* 771 F. Supp. 771 (E.D.La. 1991), which involved charges imposed directly on ERISA plans, and from other cases that have occasionally arisen under ERISA involving state "mandatory benefits" laws.

record in this case, it cannot be said whether the rate system held the cost of hospital care below what it would have been in the absence of regulation, raised it above what it would otherwise have been, or had no substantial impact at all. Petitioners' repeated assertions that the rate system had a net detrimental economic impact on them is unsubstantiated. *See* Sup.Ct.R. 15.1.

II. The Proceedings Below.

In 1990, despite the fact that hospital rates in New Jersey were then generally lower than rates in nearby states, a number of self-insured employee benefit plans ("the Plans") filed suit in the United States District Court for the District of New Jersey, asserting that the State's rate system was preempted by ERISA. The Plans also asserted that the rate system resulted in a taking of their property without just compensation, and constituted an unlawful tax.

With respect to their preemption claim, the Plans contended that, because rates promulgated under the regulatory scheme included charges for uncompensated care, the Medicare cost-shift and payor differentials, plan administrators were effectively being compelled to divert plan resources to the benefit of non-beneficiaries, in direct violation of their fiduciary obligations under ERISA. In response, the State asserted that the challenged charges represented bona fide components of a regulated rate and thus did not constitute a diversion of plan assets, and that the rate system did not "relate to" ERISA plans but rather set the price of hospital care for patients.

In the District Court, all parties moved for summary judgment, and on May 27, 1992, the court (Hon. Alfred Wolin, U.S.D.J.) issued a decision holding in the Plans' favor on their preemption claim. In its decision, the District Court found that New Jersey's rate system related to employee benefit plans because it forced them "to structure benefits in a particular manner and subject[ed] the benefit plans to inconsistent regulations" from one state to another (80a).* The court rejected the Plans' constitutional arguments (85a).

The District Court thereafter entered an order enjoining the State and hospitals in the state from enforcing the contested rate statutes against the Plans. Surprisingly, the District Court also enjoined enforcement of the rate statutes against plan *beneficiaries*, because in the District Court's expansive view ERISA not only precluded the State from imposing the disputed charges against employee benefit *plans* (the rate system imposed no such charge), but also precluded it from imposing the charges against patients who happened to be enrolled in such plans (the rate system did impose such a charge, against *all* patients) (*See*, Appendix to this Brief).

On June 24, 1992, before the District Court's order took effect, the United States Court of Appeals for the

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*The District Court was unable to support this holding with a citation to any provision of state law requiring employee benefit plans to structure their benefits in any specified manner. Petitioners are likewise unable to do so anywhere in the four petitions they have filed. No such provision exists. (Appendix citations are to the appendix filed by petitioner NYSA-ILA Welfare Fund.)

Third Circuit issued a stay pending appeal. On appeal, in an opinion dated May 14, 1993, the Third Circuit reversed. The Third Circuit rejected the District Court's unsupported conclusion that New Jersey's rate system "force[d] employee benefit plans to structure benefits in a particular manner" (80a), and noted that, to the contrary, "New Jersey's scheme does not direct ERISA plans to structure their benefits or conduct their internal affairs in any particular way." (26a-27a). The Court of Appeals acknowledged that the rate system, by setting the price of hospital care in New Jersey, had an economic impact on employee benefit plans, but concluded that such an impact did not necessitate or justify a finding of preemption under the applicable decisions of this Court (26a).

With respect to the plans' contention that the rate system compelled them to divert plan assets to non-beneficiaries, the Third Circuit noted that this argument, if accepted, would give rise to a duty on the part of plan administrators to " 'look through' the pricing structure of every health care provider to assure that the price of the services rendered a particular patient directly correlates with the cost of those services." (31a). Such a duty, the court continued, would prove a practical impossibility in view of the "many forms of state regulation . . . which result in increases in the cost of [hospitals'] doing business." (31a). The court therefore concluded that Congress did not intend to impose such a duty on plan administrators, just as it never intended, through ERISA, to preempt states from exercising their traditional far-reaching regulatory powers over hospitals (32a).

Summarizing its preemption holding, the court concluded that New Jersey's former rate system was a

> generally applicable law which (1) is not intended to regulate the affairs of ERISA plans, (2) neither singles out such plans for special treatment nor predicates rights or obligations on the existence of an ERISA plan, and (3) does not have the effect of either dictating or restricting the manner in which ERISA plans structure or conduct their affairs or the effect of impairing their ability to operate simultaneously in more than one state. We have found no case that has held such a law to be preempted . . . and we decline to so hold. [30a].

The Third Circuit also rejected the Plans' "takings" arguments (22a). Applying the standards of *Penn Central Transportation Co. v. City of New York*, 438 U.S. 104 (1978), the court found that the rate system did not interfere with the plans' investment-backed expectations, but merely adjusted "the benefits and burdens of economic life to promote the common good." *Connolly v. Pension Benefit Guaranty Corp.*, 475 U.S. 211, 225 (1986).

In dissent, Judge Nygaard wrote that the case "tests the outer limits of ERISA preemption" (32a), but that he would affirm the District Court's judgment. Judge Nygaard was persuaded that a preemptive "relation" between the rate system and ERISA plans existed because the rate system, as all parties acknowledged, would not be viable if ERISA plans and their beneficiaries were excluded from it.

III. New Jersey's Deregulation of Hospital Rates.

During the time that this matter was before the Third Circuit, New Jersey abolished its hospital rate system,

which had been politically controversial from its outset, and deregulated hospital rates. 1992 N.J. Laws, c.160. In an attempt to avoid the price volatility and disruptions that might otherwise arise with deregulation, the Legislature imposed one-year revenue caps on all hospitals, but as of January 1, 1993, the rate system that is the subject of this case ceased to exist.

Although this development rendered the Plans' claims for prospective relief moot, it did not render moot their attempt to avoid responsibility for paying hospital bills issued to their plan members during the pendency of the action – a responsibility, it bears repeating, imposed upon them by their own governing plan instruments, not by the rate system. The Third Circuit accordingly proceeded to decide the appeal before it (22a).

REASONS FOR DENYING THE WRIT

I. Summary of Argument.

In urging the Court to grant certiorari, petitioners assert that the opinion below conflicts with applicable ERISA decisions of this Court and other circuits. This assertion does not withstand scrutiny. The opinion below adheres to settled principles of preemption law, reaches a result that accords with this Court's ERISA decisions, and expressly follows the one other Court of Appeals decision to address a similar issue, *Rebaldo v. Cuomo*, 749 F.2d 133 (2d Cir. 1984), *cert. denied*, 472 U.S. 1008 (1985) (upholding New York's hospital rate system against an ERISA challenge).

Petitioners correctly maintain that this Court, in its recent ERISA decisions, has reaffirmed that ERISA's pre-emptive scope is broad, *see, e.g., FMC Corp. v. Holliday,* 498 U.S. 52, 58 (1990), but this uncontroversial point was not lost on the court below. The Court of Appeals recognized that the legal inquiry did not end there, however, since it remains true under recent decisions that ERISA's preemptive reach, though broad, is not without limits, and that state laws of general applicability having only a tenuous, remote or peripheral connection with employee benefit plans are not preempted. *District of Columbia v. Greater Washington Board of Trade,* 113 S.Ct. 580, 583 (1992); *Ingersoll-Rand Co. v. McClendon,* 498 U.S. 33, 39 (1990).

Although petitioners cast themselves as defenders of this Court's ERISA jurisprudence, the result they seek to achieve is far outside the domain of established law. Petitioners' central thesis – which they understandably choose not to state in express terms – is that ERISA precludes states from engaging in hospital rate regulation. Thus, at the same time that petitioners assert that ERISA provides a federal exemption from New Jersey's rate system for their plan beneficiaries, they also acknowledge, and even stress, that any hospital rate system that excluded patients covered by employee benefit plans from its scope would, as a practical matter, be unworkable. *See, e.g.,* Petition of United Wire, Metal & Machine Health and Welfare Fund at 21-22.

As is clear on a moment's reflection, if the latter point is true (and it quite clearly is), it follows that ERISA effectively prohibits states from engaging in hospital rate regulation. *Cf. Travelers Inc. Co. v. Cuomo,* 813 F.Supp. 996,

1006 (S.D.N.Y. 1993) *appeal pending* (holding New York's hospital rate system to be preempted; the court acknowledged that, under its legal analysis, it would follow that "ERISA preempts all state hospital rate-setting statutes.") From a public policy standpoint, such a result might or might not be beneficial (the data from New Jersey are inconclusive), but from a legal standpoint there is no reason to think that Congress intended to achieve that result when it enacted ERISA. To the contrary, Congress has consistently encouraged state efforts to contain health care costs. *See, e.g.*, 42 U.S.C. § 1395ww(6)(1) (authorizing the Secretary of Health and Human Services to waive Medicare's rate schedule and to participate in state "hospital reimbursement control systems").

Petitioners' underlying thesis is not only at odds with Congressional intent, but rests on a legal paradox. Under clearly established law, any state system of hospital rate regulation that purported to *exclude* employee benefit plans and their beneficiaries from its scope would be flatly preempted. *Mackey v. Lanier Collection Agency & Services, Inc.*, 486 U.S. 825 (1988) (Georgia garnishment statute providing exemption for employee benefit plans "related to" such plans and was preempted). If petitioners' position were upheld, therefore, ERISA would prevent states from including *or* excluding plan beneficiaries from a rate-setting system – which is again to say that states could not engage in rate regulation at all.

The Court of Appeals did not depart from established law in rejecting petitioners' boundless interpretation of ERISA. The decision below comports with the applicable precedents of this Court, presents no conflict with any other circuit court decision, and is sound on its

own merits. With the repeal of the rate system, any arguable "special and important reasons" that might once have existed to warrant this Court's involvement have vanished, Sup.Ct.R. 10, and the petitions for certiorari should accordingly be denied.

II. The Decision Below Represents a Correct Application of Settled ERISA Law and Is Not in Conflict With the Law of Any Other Circuit.

A. ERISA Preemption Standards.

ERISA preempts "any and all State laws insofar as they may now or hereafter relate to any employee benefit plan." 29 U.S.C. § 1144(a). In determining whether a state law "relates to" employee benefit plans under the statute, "as in any preemption analysis 'the purpose of Congress is the ultimate touchstone.' " *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 747 (1985) (quoting *Malone v. White Motor Corp.*, 435 U.S. 497, 504 (1978)).

Congress' purpose in enacting ERISA was "to safeguard employees from the abuse and mismanagement of [employee benefit] funds." *Massachusetts v. Morash*, 490 U.S. 107, 112 (1989). To effectuate this purpose, ERISA imposes uniform federal standards on reporting, disclosure and fiduciary responsibility, 29 U.S.C. §§ 1021-1031, 1101-14, but a state law need not intrude upon these specific subject areas to be preempted, nor need its relation to employee benefit plans be direct or express. *FMC Corp. v. Holliday*, 498 U.S. 52, 58-59 (1990). Rather, a state law "relates to" employee benefit plans if, within the "broad common-sense meaning of that

phrase," it "has a connection with or reference to" such plans. *Ingersoll-Rand, supra,* 498 U.S. at 39; *see also Pilot Life Ins. Co. v. Dedeaux,* 481 U.S. 41, 47 (1987).

On the other hand, a state law that has only a "tenuous, remote or peripheral connection with covered plans . . . as is the case with many laws of general applicability" will not be preempted. *District of Columbia v. Greater Washington Board of Trade,* 113 S.Ct. 580, 583 n.1 (1992); *Ingersoll-Rand, supra,* 498 U.S. at 39 (generally applicable statutes that make no reference to or function irrespective of benefit plans not preempted). Preemption follows only if a state law relates to employee benefit *plans,* moreover. *Fort Halifax Packing Company, Inc. v. Coyne,* 482 U.S. 1, 8 (1987) ("Congress' choice of language is significant" in that it preempts only laws that relate to plans); *Ingersoll-Rand, supra,* 480 U.S. at 39 ("only state laws that relate to benefit plans are preempted"); *cf. Alessi v. Raybestos-Manhattan, Inc.,* 451 U.S. 504, 523 (1981) (Congress, in enacting ERISA, "meant to establish pension plan regulation as exclusively a federal concern").

B. Discussion.

The decision below represents a straightforward application of these settled legal standards. The Court of Appeals examined each asserted connection between the Plans and the rate statutes, and rightly concluded that, under the ERISA decisions of this Court, none of them established the requisite preemptive "relation." In so holding, the court was guided not only by the decisions of this Court (24a-26a), but also by the one other Court of Appeals decision to address an ERISA challenge to a

state system of hospital rate regulation, *Rebaldo v. Cuomo*, 749 F.2d 133 (2d Cir. 1984), *cert. denied*, 472 U.S. 1008 (1985).

As they did below, petitioners vigorously assert that *Rebaldo* is no longer good law because it pre-dates this Court's decisions in *FMC Corp.* and *Ingersoll-Rand Co.*, and because certain passages from the Second Circuit's opinion take a narrower view of ERISA's preemptive scope than the Court espoused in those later cases. The court below, however, was careful to limit its reliance on *Rebaldo* to those portions of the opinion that remain legally sound. In particular, the court below embraced the observation made in *Rebaldo* that a finding of preemption cannot be based on the mere fact that a state statute or regulation affects a plan's "cost of doing business" since many (if not all) types of state regulations have such an effect. 749 F.2d at 138-39. In making that observation, the Second Circuit was not announcing a new or controversial rule of law; it was stating a plain fact, and nothing in the ERISA cases that have been decided since *Rebaldo* erodes the Second Circuit's wholly logical reasoning on this score. *Accord Lane v. Goren*, 743 F.2d 1337, 1340 (9th Cir. 1984) (state statutes prohibiting employment discrimination not preempted despite the fact that such laws, like laws "regulating zoning, health and safety, increase the operational costs of ERISA trusts").

Another intrinsically sound aspect of the *Rebaldo* opinion is its recognition that whether or not states engage in rate regulation, hospitalization costs will always vary from state to state and that, in consequence, statutes that merely set the price of hospital care within a given state cannot be said to subject ERISA plans to

inconsistent local regulation. 749 F.2d at 139. Petitioners are unable to point to any flaw in this syllogism, but assert that New Jersey's rate statutes did more than set the price of hospital care because it imposed a "disproportionate" share of certain costs on ERISA plans. Thus, petitioners inveigh that, in the last years of the rate system, ERISA plan participants constituted only 15% of New Jersey's hospital patients but were assessed with 40% of the challenged "cost shifts."

Although plausible on its face, petitioners' "disproportionality" argument turns out, on examination, to be an exercise in statistical sophistry. The seeming inequity of the distribution of the costs shifts evaporates when it is recalled that the largest of the "cost shifts" – by far – related to uncompensated care, *i.e.*, care rendered to nonpaying or underpaying patients. By definition, such patients (who unfortunately constitute a substantial portion of the total patient population themselves) will not bear their "proportional" share of costs; rather they will *cause* hospitals to have to seek to recover those costs from all other patients, thus *creating* a "disproportionate" load for those patients.

To the extent petitioners' "disproportionality" argument does more than reflect the fact that hospitals in New Jersey, as in other states, incur substantial uncompensated care costs, it is still lacking in force. The "cost shift" that arose from Medicare's below-market reimbursement rates was as much a product of federal law as it was of New Jersey's rate system, and petitioners provide no support for the notion that Congress intended ERISA plan participants, alone among non-Medicare patients, to be exempted from such costs. Likewise, the challenged

"cost shift" relating to payor differentials resulted in no true "disproportion," since such differentials were granted only on the basis of demonstrated economies benefiting the hospital system as a whole. Nothing in the record suggests any gross disparity between the size of the payor differentials and the benefits bestowed.

Petitioners' aspersive descriptions of the challenged "cost shifts" notwithstanding, *see, e.g.*, NYSA-ILA Petition at 7-8,* each of the charges in question corresponded to a real cost of doing business as a hospital, and consequently each of the charges was a legitimate component of a regulated hospital rate. That being so, petitioners' preemption argument amounts to a claim that, through ERISA, Congress has given plan administrators unilateral power (or, as the Court of Appeals put it, a duty) to determine for themselves and their plan beneficiaries what constitutes a "reasonable" hospital bill. Unpersuasive as this contention is on first blush, it becomes even less attractive when one considers that, were it to be upheld, federal courts would become the arbiters of everyday billing disputes between ERISA plan members and healthcare practitioners, and would have to develop

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*Petitioners' oft-repeated assertion that New Jersey's rate system was deliberately designed to target ERISA funds and to discriminate against employee benefit plans is more than aspersive; it is false. *See* Sup.Ct.R. 15.1. Since the rate system imposed no coverage obligations on ERISA plans (or any other third-party payors), it was fundamentally incapable of "discriminating" against them in the fashion complained of; perhaps more to the point, petitioners are unable to show any respect in which ERISA plans or their beneficiaries were treated less favorably than ordinary commercial insurers and their beneficiaries.

a new body of federal common law to resolve such disputes.*

While the powers bestowed upon plan administrators under ERISA are broad, they convey no license to "mark down" hospital bills on behalf of plan members. *Rebaldo, supra,* 749 F.2d at 138-139 (rejecting the idea that ERISA plans lead a "charmed existence"). They *do* encompass a power to structure plan benefits to cover so much – or so little – of members' hospital bills as may be deemed desirable, but New Jersey's former rate statutes did not trammel upon or in any way limit that power. *Compare Metropolitan Life Ins. Co. v. Massachusetts,* 471 U.S. 724, 739 (1985) (mandatory benefits law "related to" employee benefit plans, but was not preempted as to insurance companies selling policies to plans); *FMC Corp. v. Holliday, supra* (anti-subrogation law preempted because it dictated how plans had to structure benefits.)

Petitioners' assertion that New Jersey's former rate statutes made express "reference" to employee benefit plans is even less compelling than their exaggerated claims of "discrimination." The *only* reference to ERISA plans in the rate statutes was contained in a provision imposing a duty on hospitals to ascertain whether a prospective patient had any form of medical coverage.

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*This would be true, it should be noted, even in states where hospital rates are not subject to state regulation. Throughout the country, the right of hospitals and doctors to collect on their bills is governed by state law, and whether that law derives from a statute or case law it "relates" to ERISA plans in exactly the same fashion and to the same extent as New Jersey's former rate laws – which is to say indirectly and peripherally.

N.J.S.A. 26:2H-18.31 (expired 1992). That provision required hospitals to

> inquire of the patient . . . whether the patient is covered by health insurance, and if so shall require documentation . . . Documentation may include a government sponsored health plan card or number, a group sponsored or direct subscription health plan card or number, a commercial identification card or claim form or a *union welfare plan identification card or claim form.* [Emphasis added.]

The obvious, and salutary, purpose of this provision was to ensure that hospitals took reasonable steps to keep their uncompensated care costs to a minimum. For petitioners, who complain so loudly about the growth of uncompensated care costs, to suggest simultaneously that the above provision ran afoul of ERISA is, to say the least, perplexing. Petitioners surely do not maintain that hospitals are prohibited by ERISA from ascertaining whether patients have some form of medical coverage, and yet they seem to be saying that hospital officials should be required to preface patient interviews with a warning to the effect of, "Under no circumstances should you tell me if you belong to a union benefit plan." Since such a disclaimer would *still* involve a "reference" to ERISA plans (at least as petitioners construe that term), the Court of Appeals did well to reject this odd contention, and broke no new legal ground in doing so. *See Pilot Life*

Ins. Co. v. Dedeaux, supra, 481 U.S. at 47 (ERISA's preemptive language should be given "its broad *common-sense* meaning"; emphasis added).*

In the final analysis, the only true "relation" between employee benefit plans and the challenged rate system is that, by setting the price of hospital care in New Jersey, the rate system had an undeniable, albeit indeterminate, economic impact on employee benefit plans. No decision by this Court has held that such an impact alone results in preemption. Petitioners assert that the Fifth Circuit has found economic impact to be sufficient to establish a preemptive "relation" in *E-Systems, Inc. v. Pogue,* 929 F.2d 1100 (5th Cir.), *cert. denied,* 116 L.Ed.2d 610 (1991), but that case involved a tax imposed specifically on persons rendering services to any "employer-employee . . . health benefit plan." Thus, the statute's relation to benefit plans was not merely economic, and was anything but "tenuous" and "peripheral"; to the contrary, it was direct and practically *exclusive.*

Petitioners also seize upon dicta from *Arkansas Blue Cross and Blue Shield v. St. Mary's Hospital, Inc.,* 947 F.2d 1341 (8th Cir. 1991), *cert. denied,* 112 S.Ct. 2305 (1992), in

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*The "reference" to employee benefit plans contained in the New Jersey Department of Health's policy statement regarding patient appeals again merely lists employee benefit plans as one possible form of third-party coverage. The policy statement (which was not itself part of the statutory rate scheme) merely recognized, as an incontrovertible fact, that employee benefit plans are a common type of third-party payor. That petitioners construe ERISA's preemptive language to mean that this fact must never be acknowledged in writing by state officials demonstrates the artificiality of their position.

an attempt to generate a conflict between the Eighth Circuit and the court below. In that case, the Eighth Circuit questioned – as the Fifth Circuit had done before it, *see Somers Drug Stores v. Corrigan Enterprises Inc.*, 793 F.2d 1456, 1467 (5th Cir. 1986) – whether the fact that a state law falls within the state's traditional police powers has any legal relevance in ERISA preemption disputes. 947 F.2d at 1350. The court left the question hanging, although it allowed that "this factor is arguably a policy consideration useful in deciding borderline" ERISA cases. *Id.*

If the Fifth Circuit or Eighth Circuit ever chose to formalize their speculative views on this rather fine point of ERISA law in a legal holding, a genuine conflict among the circuits would clearly exist. *Compare, e.g., Aetna Ins. Co. v. Borges*, 869 F.2d 142, 144 (2d Cir.), *cert. denied*, 493 U.S. 811 (1989) (observing, in an ERISA case, "we must assume 'that the historic police powers of the State were not to be superseded . . . unless that was the clear and manifest purpose of Congress' "; quoting *Ray v. Atlan. Richfield Co.*, 435 U.S. 988, 994 (1978)). It seems doubtful that a genuine conflict on this point will ever arise, however, since this Court has made perfectly clear that, in addressing questions of preemption under ERISA – as under any other federal statute – the Court "must presume that Congress did not intend to preempt areas of traditional State regulation." *Metropolitan Life Ins. Co. v. Massachusetts, supra*, 471 U.S. at 740 (1985). This negative presumption is bottomed on basic precepts of federal-state comity; thus, for instance, in *Fort Halifax Packing Co. v. Coyne, supra*, the Court wrote:

> ERISA pre-emption analysis 'must be guided by respect for the separate spheres of governmental authority preserved in our federalist system.' [482 U.S. at 19, *quoting Alessi v. Raybestos-Manhattan, Inc*, 451 U.S. 504, 522 (1982)].

It is true, as the Eighth Circuit observed in *Arkansas Blue Cross, supra,* that the Court has not invoked this canon of statutory construction in its most recent ERISA decisions. Given the extensive body of ERISA law on which the Court is now writing, there would seem little need. Neither the Third Circuit nor any other Court of Appeals would be at liberty to assume that, by the omission, the Court has implicitly overruled its earlier decisions, *Rodriguez DeQuijas v. Shearson/American Express, Inc.*, 490 U.S. 477, 484 (1989), and no reason exists to think that it has.

The applicable decisions of this Court and of other circuits establish that where, as here, a regulatory scheme has an indirect economic impact on ERISA plans, a number of considerations must be taken into account to determine if the scheme is preempted. Those considerations include whether the law in question involves an exercise of traditional state police powers, *Metropolitan Life, supra,* as well as whether it interferes with the administration of ERISA plans, or mandates that they provide a particular type or level of benefit, or subjects them to inconsistent regulation. *See, e.g., Aetna Life Ins. Co. v. Borges, supra,* 869 F.2d at 145-146 (surveying ERISA cases and noting that Congress "could not possibly have meant to preempt all laws having any impact on plans, no matter how small or how tangential"). The Court of Appeals examined each of these relevant criteria, and

concluded that they did not support a finding of preemption. The court's legal analysis and conclusion were consistent with and faithful to existing law, and its rejection of petitioners' overreaching contention that ERISA precludes state regulation of hospital rates presents no reason for further review by this Court.

III. The Court of Appeals' Holding That New Jersey's Hospital Rate-setting System Does Not Result in a Compensable "Taking" of the Plans' Property Presents No Questions Requiring Review by This Court.

The NYSA-ILA Plan, alone among petitioners, seeks review of the Court of Appeals' affirmance of the District Court's dismissal of the Plans' "takings" claim. The Court of Appeals' decision on this point represents a sound and even elementary application of established law, and does not remotely meet any of the criteria for issuance of a writ of certiorari.

Outside the area of "physical" takings, a three-prong test determines whether a compensable taking has occurred. Under that test, courts must examine the character of the governmental action involved, the economic impact of that action on the claimant, and the extent to which it has interfered with the claimant's "distinct investment-backed expectations." *Penn Central Transportation Co. v. City of New York*, 438 U.S. 104, 124 (1978).

The challenged governmental action here is the inclusion of certain "indirect" costs in regulated hospital rates. The costs in question, while indirect, are true costs incurred by hospitals and, in providing for them to be

spread among all hospitals and hospital patients, New Jersey's rate system sought merely to adjust "the benefits and burdens of economic life to promote the common good." *Connolly v. Pension Benefit Guaranty Corp.*, 475 U.S. 211, 223 (1986). The economic impact of New Jersey's rate system upon the Plans, as has been noted, is indeterminate since hospital rates in New Jersey under the system were roughly in line with, but somewhat lower than, rates in nearby states. Clearly, though, the system did not interfere with the Plans' "investment-backed expectations." The Plans exist in order to pay the medical bills of their beneficiaries, and have never had a reason to think that their beneficiaries occupy a special status among hospital patients exempting them from charges borne by other patients. The Court of Appeals' rejection of Petitioners' unmeritorious takings argument thus needs no attention from this Court.

CONCLUSION

For the foregoing reasons, the petitions for writ of certiorari should be denied.

Respectfully submitted,

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Dated: September 29, 1993

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NEW JERSEY

UNITED WIRE, METAL & MACHINE HEALTH AND WELFARE FUND, et al.,	Civil Action No. 90-2639 (Consolidated)
Plaintiffs,	AMENDED ORDER
v.	(Filed June 4, 1992)
MORRISTOWN MEMORIAL HOSPITAL, et al.,	
Defendants.	

The Court hereby amends its Order dated May 27, 1992 as follows:

It is on this 4th day of June, 1992,

ORDERED, that the state defendants are permanently enjoined from enforcing the provisions stated in its May 27, 1992 order as to participants in ERISA plans only.

/s/ Alfred M. Wolin
ALFRED M. WOLIN, U.S.D.J.

Supreme Court, U.S.
FILED
SEP 30 1993
OFFICE OF THE CLERK

No. 93-194

IN THE
Supreme Court of the United States
OCTOBER TERM, 1993

UNITED WIRE, METAL & MACHINE HEALTH AND WELFARE FUND; TRUSTEES OF THE OPERATING ENGINEERS LOCAL 825 WELFARE FUND; TEAMSTERS LOCAL 11 BENEFIT PLAN; LOCAL 807 LABOR-MANAGEMENT HEALTH FUND; THE TRUSTEES OF THE LOCAL 807 LABOR-MANAGEMENT HEALTH FUND; LOCAL 464A UNITED FOOD AND COMMERCIAL WORKERS UNION GROUP REIMBURSEMENT WELFARE FUND; and LOCAL 945 IBT WELFARE FUND,

Petitioners,

v.

MORRISTOWN MEMORIAL HOSPITAL; FRANCES J. DUNSTON, in her capacity as New Jersey Commissioner of Health; *et al.*,

Respondents.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Third Circuit

BRIEF OF THE NATIONAL COORDINATING COMMITTEE FOR MULTIEMPLOYER PLANS AS AMICUS CURIAE IN SUPPORT OF PETITIONERS

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IN THE

Supreme Court of the United States

OCTOBER TERM, 1993

No. 93-194

UNITED WIRE, METAL & MACHINE HEALTH AND WELFARE FUND; TRUSTEES OF THE OPERATING ENGINEERS LOCAL 825 WELFARE FUND; TEAMSTERS LOCAL 11 BENEFIT PLAN; LOCAL 807 LABOR-MANAGEMENT HEALTH FUND; THE TRUSTEES OF THE LOCAL 807 LABOR-MANAGEMENT HEALTH FUND; LOCAL 464A UNITED FOOD AND COMMERCIAL WORKERS UNION GROUP REIMBURSEMENT WELFARE FUND; and LOCAL 945 IBT WELFARE FUND,

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BRIEF OF THE NATIONAL COORDINATING COMMITTEE FOR MULTIEMPLOYER PLANS AS AMICUS CURIAE IN SUPPORT OF PETITIONERS

INTRODUCTION

The National Coordinating Committee for Multiemployer Plans ("NCCMP") urges this Court to review the decision below. By effectively creating a judicial exemption from ERISA preemption for state health care financing statutes—without regard to their impact on employee benefit plans—on the grounds that these laws fall within traditional state police powers, the Third Circuit's

ruling threatens to disproportionately burden self-funded multiemployer health benefit plans and therefore to undermine the ability of these plans to continue to provide benefits to their participants and beneficiaries.

The decision below is inconsistent with the plain language of ERISA's preemption provision as well as with every decision of this Court which has interpreted the scope of ERISA preemption. Instead, the Third Circuit fashioned an expanded "cost of doing business standard" to determine whether a state law—despite its inordinate impact on self-funded ERISA plans—should nevertheless survive ERISA preemption because the state law promotes a social objective that the state wishes to encourage and to regulate under its police powers. The decision below therefore transcends its subject matter; *i.e.*, whether New Jersey's hospital rate-setting statute is preempted and pierces the very heart of what Congress intended to achieve through ERISA preemption; namely, the insulation of self-funded employee benefit plans from all state regulations that affect the administration, structure, or solvency of such plans, except for those specific matters which Congress—in the exercise of its legislative powers—expressly exempted.

INTEREST OF THE NATIONAL COORDINATING COMMITTEE FOR MULTIEMPLOYER PLANS

The NCCMP is a nonprofit, tax-exempt organization that was formed after the enactment of ERISA to participate in the further development of employee benefits legislation, government regulations promulgated to implement ERISA, and other laws affecting multiemployer plans. Currently, more than 190 multiemployer plans and related international unions, located in at least 37 states, are affiliated with the NCCMP. These plans are representative of all of the union's multiemployer plans, which cover more than nine million workers. The decision below has far-reaching adverse consequences for all multiemployer plans and, therefore, is particularly adverse to

the interests of NCCMP affiliates, which represent the majority of participants in such plans.

Because of the broad range of the NCCMP's constituent organizations and its contacts with hundreds of trustees charged with the administration of multiemployer plans in accordance with ERISA's fiduciary duty rules and principles, the NCCMP believes that it is qualified to advise the Court of the practical implications of the decision below for multiemployer plans and to state the position of the trustees, participants, and beneficiaries of such plans. The NCCMP has participated as an *amicus curiae* in numerous cases involving important issues affecting multiemployer plans. *See, e.g., Local 144 Nursing Home Pension Fund, et al. v. Demisay,* —— U.S. ——; 113 S. Ct. 2252 (1993); *Concrete Pipe & Products of California v. Construction Laborers Pension Fund for Southern California,* —— U.S. ——, 113 S. Ct. 2264 (1993); *FMC Corp. v. Holliday,* 498 U.S. 52 (1990). The NCCMP respectfully submits this brief as *amicus curiae* in support of Petitioners pursuant to Rule 37.2. Written consents from all parties have been filed with the Clerk of the Court.

SUMMARY OF REASONS FOR REVIEW

In ruling that the DRG surcharges do not "relate to" employee benefit plans in such a way as to trigger preemption, the court below impermissibly carved out a judicial exemption from ERISA preemption for state health care financing statutes on the erroneous assumption that Congress did not intend to frustrate the efforts of states to regulate health care costs through their police powers.

The issue is one of great national importance because there are many states which already have or are developing programs to subsidize the uninsured and uninsurable by imposing taxes, premiums, or surcharges on plan participants. To the extent such premiums are payable by ERISA plans, and are not related to the benefits received by the participants, these payments constitute a prohibited

diversion of plan assets to fund the benefits of persons other than participants and beneficiaries. Such cost-shifting violates the fundamental premise of ERISA, that plan assets must inure *exclusively* to the benefit of its participants and beneficiaries. 29 U.S.C. § 1104(a)(1)(A).

Notwithstanding a clear conflict with express prohibitions in ERISA, the court validated the DRG surcharges by mischaracterizing them as a mere cost of doing business in the state. The court thereby disregarded the nature of collectively bargained multiemployer plans and the manner in which such plans are founded and funded, while also intruding upon an area reserved exclusively to the legislative powers of Congress.

The language of ERISA § 514 does not tolerate judicial exemptions for state laws relating to ERISA plans, even if those laws serve useful social purposes. Rather, § 514(a) supersedes *all* state laws relating to employee benefit plans other than those which Congress expressly exempted. Congress knew how to draft an express exemption for state health care financing statutes and did so for Hawaii's Prepaid Health Care Act, 29 U.S.C. § 1144(b)(5)(A). More recently, legislative efforts have been made—to date unsuccessfully—to enact additional exemptions for other state health care financing laws, including DRG statutes similar to New Jersey's.

The NCCMP seeks review because of its fundamental belief that the health care crisis must be resolved by national health care reform, not by piecemeal state legislation which, if enforced by federal courts, could cripple multiemployer plans. The NCCMP also seeks review because it is concerned that the economic impact of other socially useful state laws will no longer figure in the preemption calculus on the assumption that such economic burdens are a mere cost of a plan's doing business in the state. Finally, the NCCMP seeks review because the Third Circuit's ruling clouds the clear standards of preemption that have been enunciated by this Court and therefore, undermines the ability of plans to govern themselves in accordance with this Court's guidelines.

REASONS FOR REVIEW

THE DECISION BELOW RAISES ISSUES OF GREAT NATIONAL IMPORTANCE WITH REGARD TO THE SCOPE OF ERISA PREEMPTION, DISPROPORTIONATELY BURDENS SELF-FUNDED MULTIEMPLOYER HEALTH BENEFIT PLANS, AND IS INCONSISTENT WITH THIS COURT'S PREVIOUS DECISIONS.

I. THE DECISION BELOW EFFECTIVELY CREATES A JUDICIAL EXEMPTION FROM ERISA PREEMPTION FOR STATE HEALTH CARE FINANCING STATUTES WITHOUT REGARD TO THE IMPACT OF THOSE STATUTES ON SELF-FUNDED MULTIEMPLOYER PLANS.

It is now well established that ERISA was enacted to promote the financial stability of employee benefit plans and to assure that their participants receive the benefits upon which they rely. *Nachman Corp. v. PBGC*, 446 U.S. 359 (1980).

It is equally well established that the costs of providing health care have escalated out of all proportion,[1] and are threatening either to destroy private welfare plans or to force those plans to take drastic measures to remain solvent, including restricting or eliminating a whole range of benefits and terminating coverage for retirees.

The New Jersey statute[2] that is the subject matter of the present petition for review was designed to contain the

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[1] *See Clinton Administration Description of President's Health Care Reform Plan, American Health Security Act of 1993, dated September 7, 1993*, BNA Special Supplement (September 13, 1993). According to this Report, health care costs are rising faster than other sectors of the economy; will consume about two-thirds of the increase in the Gross Domestic Product ("GDP") for each American for the rest of the decade; and will grow from 14% of the GDP to 19% without regard to an expansion of coverage to insure all Americans. (S-3.)

[2] New Jersey Health Care Facilities Planning Act, as amended and supplemented by the Health Care Cost Reduction Act, N.J.S.A. 26:2H-1 *et seq.*, and regulations promulgated thereunder, N.J.A.C. 8: 31B *et seq.* The statute will be referred to henceforth as the "DRG statute." The DRG statute was amended, effective January 1,

costs of health care within the state and to assure the financial solvency of New Jersey hospitals, which are prohibited by law from denying admission to any patient based on the ability to pay.

However, to achieve this end, in substantial part, the New Jersey law imposed three separate surcharges on each patient's hospital bill, which were payable by ERISA plans although the charges had no relation to the services provided or benefits received by the plan's participants and beneficiaries; *e.g.*, a 19.1 percent surcharge to reimburse the hospital for the costs of providing uncompensated care (including bad debts); a 7 percent surcharge to reimburse the hospital for the difference between federal Medicare payments for specific services provided and the DRG rates established for those services (payable by non-Medicare recipients); and a maximum 11 percent surcharge to reimburse the hospital for discounts permitted to certain high volume insurers such as Blue Cross and Blue Shield and to plans having open enrollment. Thus, in addition to the base DRG rates, which were designed both to contain the cost of medical care while compensating hospitals for the direct and indirect costs associated with providing specific services, and which in many cases far exceeded the actual itemized cost of benefits received by plan participants,[3] the three surcharges required ERISA

1993, to deregulate rates. However, the amendments do not render the issues moot. See footnote 5, *infra*.

[3] For example, according to testimony given by the Fund Administrator of the Steamfitters Welfare Fund, Local 475, at a Public Hearing before the Assembly Corrections, Health and Human Services Committee on DRG Hospital Reimbursement System and State Waiver for Medicare (December 20, 1984), the basic DRG rate for claims submitted to the Fund often exceeded actual itemized costs by 100%-500%. In a recent letter to the NCCMP, the same Fund Administrator has advised that the Fund's escrow account currently contains the sum of $462,405.62 for DRG claims in excess of itemized costs as compared with $40,000 for claims in which actual costs were more than the assigned DRG. As pointed out by Petitioners, one feature of the DRG statute that was particularly adverse to self-funded plans was the limited inability to appeal excessive and inequitable DRG rates.

plans to pay additional charges of up to 37 percent of the base DRG rate to reimburse New Jersey hospitals for the cost of providing treatment to persons who were not participants or beneficiaries of the plans.

The financial impact of a 37 percent increase on charges payable by ERISA plans is staggering. As Judge Nygaard pointed out in his dissenting opinion:

> The surcharges are paid not by the general public at large, but by the less than 25 percent of the population who use hospital services. Of those 25 percent, about 75 percent receive the uncompensated care assessments challenged here. ERISA plan participants comprise only about 15 percent of the hospital patients, but pay about 40 percent of the more than $1.1 billion shortfall generated by the state-mandated cost shifts.

(App. 37a).[4]

One NCCMP affiliate, the Hotel Employees and Restaurant Employees International Union Welfare Fund, recently advised that it has placed the disputed portion of each patient's bill into an escrow account.[5] Checks paid into the escrow account in 1992 and the first few months

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[4] References to the court of appeal's decision will refer to the Appendix to the Petition for Certiorari filed by the NYSA-ILA Welfare Fund in No. 93-115.

[5] As noted in the petition of the Carpenters Welfare Fund (No. 93-193, p. 12), some plans, during the pendency of this litigation, have paid the DRG surcharges under protest, while others have placed the amounts into escrow, reserving the right to assert claims for reimbursement in the event the DRG surcharges are held to be preempted. For this reason alone, the court of appeals has conceded that the plans' claims are not moot, although New Jersey amended the DRG statute, effective January 1, 1993, to eliminate the DRG system of rate-setting in favor of deregulated market competition. L. 1992, c 160, N.J.S.A. § 26:2H-18.51 *et seq.* Under the new law, New Jersey hospitals will still be prohibited from denying access to treatment on the basis of an individual's ability to pay. However, hospitals will be free to set their own rates and will receive reimbursement from a new Health Care Subsidy Fund which, for the next three years will be financed in substantial part by revenues from employers and employees.

of 1993 alone total $1,172,096.14. The Fund paid an additional $533,503.25 under protest.

Notwithstanding the enormous impact on self-funded multiemployer plans, the court of appeals opined that

> [T]his effect is no different in kind . . . from any state regulation that increases the cost of goods or services that hospitals consume and pass on in hospital costs, *i.e.*, utility costs, the wages of its employees, waste disposal costs, etc. (App. at 26a.)

Therefore, the court concluded that the DRG statute was "a generally applicable law" that was not intended to regulate the affairs of ERISA plans; did not single out such plans for special treatment; was not predicated on the existence of ERISA plans; had no effect on the structure or administration of ERISA plans; and, in sum, did not "relate to" ERISA plans in such a manner as to trigger preemption under § 514(a).

In reaching the conclusion that the DRG statute was not preempted, the court stated that it was "unwilling to attribute to Congress and § 514 an intent to frustrate the efforts of a state, under its police power, to regulate health care costs. In particular, we are unwilling to infer from ERISA's prohibition against applying fund assets for the benefit of others a Congressional intent to foreclose health care cost regulation of the kind here challenged." (App. at 31a-32a.)

The NCCMP submits that the court's rationale suffers from two fatal flaws. First, there is nothing to support the proposition that Congress intended to leave states free to regulate state health care at the expense of ERISA plans, under the authority of their traditional state police powers. Second, there is nothing to support the court's view that ERISA leaves states free to compel self-funded plans to divert trust assets to fund the benefits of persons other than plan participants and beneficiaries.

In its obvious desire to support the well-intended social objectives articulated in New Jersey's DRG statute, the

court of appeals completely disregarded the nature of collectively bargained self-funded ERISA plans, confounded the generally applicable costs of doing business with the express use of fund assets to subsidize a particular group of nonparticipants, and impermissibly intruded upon an area reserved exclusively to the legislative powers of Congress. The NCCMP is concerned that unless the ruling is reviewed and reversed, other courts may carve out judicial exceptions to ERISA's preemption clause, not only for state health care financing laws but for other state efforts to promote social goals at the expense of self-funded plans whose resources are limited.

A. The Third Circuit's Ruling is Inimical to ERISA Because it Fails to Appreciate the Nature of Multiemployer Plans and Requires the Diversion of Fund Assets to Pay for the Benefits of Nonparticipants on the Grounds that this is a Mere Cost of Doing Business in the State.

Multiemployer employee welfare benefit plans are plans created by the parties to collective bargaining agreements for the purpose of providing health and welfare benefits to workers and their families. In addition, many welfare benefit plans provide sorely needed coverage to retirees.

Most collectively bargained plans are self-funded through the ongoing contributions of several, hundreds, or even thousands of employers in one or more industries involving participants working or living in one, several, or many states. The contributions are pooled for investment to provide benefits to all participants in the plan, and their families. A key feature of multiemployer plans is that participants can move from one contributing employer to another within the plan without losing their benefit rights, making such plans a model for portability.

The parties to collective bargaining agreements negotiate the rate of contributions the employer will agree to pay during the life of the contract, as well as the job classifications to be covered. As Mr. Robert A. Georgine, Chairman of the NCCMP, explained in a letter to the

Speaker of the House,[6] urging a national solution to the health care problem rather than "the current crazy-quilt, state-by-state system that is killing multiemployer health plans":

> Collectively-bargained 'employer' contributions to multi-employer health plans are part of a covered worker's compensation package for his or her labors. Such contributions are in lieu of cash wages. Workers forego a portion of their wages and wage increases to have their employers contribute to multiemployer health plans. Increases in plan costs caused by taxes and other government-imposed charges divert plan assets away from benefits for the covered workers and their families. Increased plan costs mean increases in the rate of contributions, and declining wages, as a greater portion of the workers' compensation package is allocated to health plan contributions instead of wages.
>
> Our plans are already troubled by the uncontrolled inflation in health care costs and cost-shifting, and covered workers are increasingly faced with benefit cutbacks and wage reductions as a result. The economic recession has exacerbated these troubles, as the lack of work causes declines in plan contribution income and increases in benefit usage.

"How," Mr. Georgine asks, "do you explain to a union construction worker that he must divert a portion of his wages to the health care provided to uninsured, nonunion construction workers" when it is precisely this kind of cost-shifting that is impeding the progress of national health care reform while "discourag[ing] the maintenance of employee health plans [and] only serves to broaden the uninsured problem in this nation." *Id.*[7]

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[6] Letter from Robert A. Georgine to the Honorable Thomas S. Foley, Speaker of the House of Representatives, dated May 21, 1993, expressing the NCCMP's views on "ERISA waivers" for state health care financing laws and urging Congress not to include such waivers in the Omnibus Budget Reconciliation Act of 1993. As will be discussed below, the waivers were not granted.

[7] As the NCCMP pointed out in its *amicus* brief in support of a multiemployer plan in *FMC Corp. v. Holliday*, 498 U.S. 52 (1990),

The answer to this question is that ERISA precludes the type of cost-shifting that was implemented by the DRG statute and reflected in the surcharges. First, although the parties to collective bargaining agreements negotiate the amount of money the employer agrees to dedicate to providing health benefits, it is the trustees of self-funded ERISA plans who normally have sole discretion and authority—under the governing trust agreement and applicable benefit plan—to determine the type and range of benefits the plan can and will provide and to establish eligibility requirements on the basis of the plan's financial resources and such actuarial considerations as the number and age of participants and previous claims experience. These are sensitive determinations that frequently require the input of the fund's actuarial consultant.

Moreover, since § 302(c)(5) of the Labor-Management Relations Act of 1947, as amended, 29 U.S.C. § 186 (5)(c) ("LMRA"), prohibits employers from making and employee benefit plans from accepting contributions except pursuant to a detailed written agreement specifying, among other things, the persons on whose behalf the contributions are being made; and since § 404(a)(1) of ERISA, 29 U.S.C. § 1104(a)(1), imposes on trustees a fiduciary obligation to act in the sole and exclusive interest of the plan's participants and beneficiaries, the basic premise of eligibility for benefits in self-funded multiemployer plans is coverage under a collective bargaining agreement. While the trust agreements of some multiemployer funds permit trustees to extend coverage to other classes of persons under participation agreements with the trustees, for example, the employees of the union

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a three-year study prepared by the Services Employees International Union, *Labor and Management: On a Collision Course over Health Care*, while recommending a 'systemic' change in the way health care is provided, stated that the number of strikes over who will pay the rising costs of health care has increased by more than 300% since 1986, and that such work stoppages in 1989 alone cost the United States economy more than $1.1 billion in lost wages and productivity. 17 *Pens. Rep.* (BNA) 375 (Feb. 26, 1990).

or of the fund, nothing in federal employee benefits law authorizes fund trustees to divert trust assets to finance the benefits of individuals who are not covered by written collective bargaining agreements or participation agreements and whom the trustees, in their sole discretion, have not admitted to participation in the fund, such as the uninsured individuals protected by New Jersey's DRG statute.[8] It follows that where trustees have sole discretion to determine questions of eligibility, as typically occurs in self-funded plans, trustees do not act arbitrarily and capriciously by refusing to pay benefits to ineligible individuals. *See Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1989).

Indeed, several provisions of ERISA explicitly prohibit the diversion of trust assets to persons other than participants and beneficiaries of the plan. For example, § 403(c)(1), 29 U.S.C. § 1103(c)(1), provides that the "assets of a plan shall never inure to the benefit of any employer and shall be held for the exclusive purpose of providing benefits to participants in the plan and their beneficiaries." Likewise, § 404(a)(1)(A), 29 U.S.C. § 1104(a)(1)(A), requires the trustees, as fiduciaries, to discharge their duties to the plan "for the exclusive purpose of providing benefits to participants and beneficiaries" while § 404(a)(1)(D), 29 U.S.C. § 1104(a)(1)(D), obligates the trustees to act in accordance with the governing plan documents as long as these documents are consistent with ERISA.

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[8] *See Doyle v. Shortman*, 311 F. Supp. 187 (S.D.N.Y. 1970), still regarded as a leading case for the proposition that employee benefit funds may, without violating § 302(c)(5) of the LMRA, extend coverage to the employees of nonunionized employers who agree to comply with the terms of the trust and who pay the appropriate contributions *if* the trust agreement permits such extensions of coverage, the trustees agree to extend it, and the employer executes an appropriate agreement; *see also Seafood Workers Health Fund Union Trustees v. Seafood Workers Health Fund Management Trustees*, 571 F. Supp. 483 (D. Mass. 1983), indicating that trustees cannot be compelled to accept such employees for participation, absent appropriate contracts.

The Third Circuit's ruling, however, requires fund trustees to violate ERISA's mandates by diverting millions of dollars to pay for the benefits of nonparticipants. Although the Third Circuit stated that it was "not troubled" by this aspect of the cost-shifting structure of the DRG statute, the NCCMP submits that the court of appeals failed to appreciate the requirements of ERISA and the LMRA, mischaracterized the surcharges as the mere cost of doing business in New Jersey, and ruled in a manner that is totally inconsistent with this Court's decision in *Local 144 Nursing Home Pension Fund, et al. v. Demisay*, —— U.S. ——, 113 S. Ct. 2252 (1993).

The issue in *Demisay* was whether a federal district court could issue an injunction under § 302(e) of the LMRA, and thereby compel the trustees of a multiemployer trust to transfer assets from that fund to a new multiemployer trust fund established by employers who had broken away from the first fund. The issue arose because the union, in negotiating a change of funds, was concerned that covered employees would not lose benefits as a result of the change. To address that concern, the affected employers made certain guarantees in their collective bargaining agreements, which created some peculiar liabilities for the new funds. To finance these liabilities, the trustees of the new funds brought an action to compel the old funds to transfer that portion of their reserves that were attributable to the employers' past contributions for the employees to be covered by the new funds, claiming that the failure to transfer these amounts created a structural defect which violated § 302(c)(5) and was remediable under § 302(e).

The gravamen of the employers' argument was that § 302(c)(5) forbids the use of an employer's contributions to provide benefits to anyone other than that employer's employees. Although the majority decided the case on the broad grounds that federal district courts do not have authority under § 302(e) to issue injunctions to compel trustees to administer employee benefit trusts in accordance with § 302(c)(5), and that breaches of trust

are remediable solely under ERISA, three members of the Court, in a strong concurring opinion that is relevant to the case at bar, decided the issue on narrower grounds, concluding that the old fund's failure to transfer assets did not violate § 302(c)(5), because this provision of the LMRA contemplates that employer contributions will be used both for the sole and exclusive benefit of the contributing employer's employees *and* the employees of similarly situated employers making contributions to the fund:

> That some portion of respondent's contributions will go to benefit the employees of other contributors is, of course, in the nature of a multiemployer plan. Such plans operate precisely as suggested by the language of § 302(c)(5), by pooling employer contributions for the joint benefit of all participating employees. Segregation of funds by an employer is neither feasible nor contemplated.

With regard to collectively bargained multiemployer plans, ERISA incorporates the requirements of § 302(c)(5). If, consistent with federal law, trustees cannot be compelled to upset the pool by diverting fund assets to subsidize the benefits of former participants who are subsequently covered by a new plan, it is clear that trustees should not be compelled to upset the pool by diverting fund assets to subsidize the benefits of individuals who were never participants in the plan. The Third Circuit's ruling fails to take proper account of the manner in which multiemployer pooled trusts are founded and funded.

Moreover, while basic DRG rates, which include indirect costs such as research and hospital maintenance, can arguably be regarded as a generally applicable cost of doing business, surcharges which have been added on to the basic DRGs for the express purpose of subsidizing hospital care for nonparticipants are a qualitatively different cost. At a minimum, these surcharges "relate to" employee benefit plans because they compel trustees to act in violation of the plan documents. Put differently, participants may be said to receive the benefit of indirect

costs such as hospital maintenance; however, they obtain no benefits from the surcharges, which also put the plans at risk.

The NCCMP is concerned that unless this Court reviews the Third Circuit's ruling, and clarifies both the nature of pooled trusts and the parameters of the "cost of doing business" exception to preemption, if there is one, other courts may uphold state laws having an inordinate impact on multiemployer plans on the grounds that the economic impact—however intrusive and oppressive—is merely a cost of doing business in the state and therefore, does not "relate to" employee benefit plans in such a manner as to trigger preemption.

B. The Third Circuit has Intruded Impermissibly Upon an Area Reserved Exclusively to Congress.

As noted above, the Third Circuit has, by judicial fiat, carved out an exception from preemption for state health care financing statutes on the assumption that Congress did not intend to prevent states from regulating health care costs under their traditional police powers even if such regulation results in the diversion of fund assets to pay for the benefits of nonparticipants. The NCCMP submits that the court's assumption is incorrect. The NCCMP is therefore concerned that the ruling, unless reviewed and reversed may prompt other courts of appeals to carve out similar exemptions, not only for state health care financing laws but also for other laws promoting important state objectives,[9] in derogation of Congress's de-

[9] It may be recalled that prior to this Court's decision in *FMC Corp. v. Holliday, supra,* the Courts of Appeals for the Third and Sixth Circuits had carved out an exemption from preemption for state no-fault insurance statutes, opining that such statutes should be "saved" because they promoted important state interests without impermissibly intruding on "core" ERISA concerns. *FMC Corp. v. Holliday,* 885 F.2d 79 (3d Cir. 1989); *Northern Group Services, Inc. v. Auto Owners Ins. Co.,* 833 F.2d 85 (6th Cir. 1987). The NCCMP filed an *amicus* brief in *Holliday* because it feared that the "core ERISA concern" standard of preemption would erode the "deemer" clause and "save" a whole variety of state statutes and common law rules regulating insurance, banking, and

termination that employee benefit plans should be regulated exclusively by federal law.

The NCCMP submits that the plain language of § 514, 29 U.S.C. § 1144, does not support the Third Circuit's assumption. First, § 514(a) clearly states that ERISA supersedes any and all state laws relating to employee benefit plans (with limited exemptions not relevant here). Nowhere in § 514 is there a legislative exemption for generally applicable state laws that also relate to employee benefit plans, no less for generally applicable state laws regulating health care. Rather, § 514(b)(2)(A) "saves" from preemption only those state laws that regulate insurance, banking, and securities (except as applied to self-insured plans which—under § 514(b)(2)(B)—are deemed not to be engaged in the business of insurance, banking, or securities for purposes of those laws), while § 514(b)(4) exempts generally applicable *criminal* laws from the reach of § 514(a).

Where Congress wished to create an exemption for state health care financing laws, it did so expressly in the statute. Thus, § 514(b)(5)(A) contains an express exemption for the Hawaii Prepaid Health Care Act while §§ 514(b)(5)(B) and (C) contain equally express limitations on the exemption.

That state health care financing laws relating to employee benefit plans are clearly preempted by ERISA unless and until *Congress* decides to exempt them is clearly evidenced by a bill which Senator Durenberger introduced

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securities since courts would be likely to differ on what they perceived as "core ERISA concerns." The NCCMP has even greater concerns with regard to the Third Circuit's ruling in *United Wire* because, in contrast to *Holliday*, which involved the scope of the "deemer" clause, the court's interpretation of § 514(a) does not even leave open the possibility of distinguishing between self-funded and insured plans to secure the greater protection which this Court has afforded self-funded plans in *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724 (1984) and in *Holliday*, 498 U.S. 52 (1990).

in September 1992.[10] That bill, entitled "State Health Care Financing Equity Act of 1992," [11] was intended to waive certain preemption requirements of ERISA by adding two paragraphs (9 and 10) to § 514(b) to exempt from the reach of § 514(a) any qualified state health financing program that imposes a tax, premium, or surcharge on health plans doing business in the state (including self-funded plans) or requires such plans to participate in a risk pool for the medically uninsurable.

The proposed bill expressly provided that states would not be prohibited from setting hospital rates prospectively under a DRG methodology which could include charges for uncompensated care, as well as for adjustments necessitated by Sections XVIII and XIX of the Social Security Act. However, states would have to apply for an ERISA waiver, and federal review and oversight was intended to be both comprehensive and pervasive, *inter alia,* to assure that the state law would be capable of fulfilling its goals and would also be nondiscriminatory.

To date, this bill has not been passed, perhaps in anticipation of national health care reform. However, four states (Hawaii, New York, Maryland, and Minnesota) have more recently applied for individual waivers from ERISA preemption—as part of the proposed Omnibus Budget Reconciliation Act of 1993 ("OBRA")—to allow them to regulate hospital rates and to permit them to recover the cost of providing indigent care by imposing surcharges and by increasing costs for health plan participants (including participants in self-funded plans). As enacted on August 4, 1993, OBRA contains no provision granting any state an exemption from ERISA preemption. P.L. 103-66 (1993).

In light of the above, it is clear that if exemptions from ERISA preemption are to be made for state health care

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[10] S. 3223, 138 Cong. Rec. S13267-02 (introduced on September 10, 1992).

[11] The bill was divided into two major sections, captioned "Waiver of ERISA Preemption for State Universal Health Plans" and "State Provider Taxes and Prospective Payment Systems."

financing statutes, the exemptions must be made by Congress and not by the courts, which are neither equipped nor authorized to solicit, process, or debate the type of broad-based information that must necessarily be considered and balanced in the course of amending a complex federal statute of great national scope, such as ERISA.

Prompt clarification of this preemption issue is essential. First, multiemployer plans have already paid millions of dollars to New Jersey hospitals under protest or have escrowed the surcharge amounts pending a decision whether the DRG statute is preempted. Second, 26 states have established risk pools to insure the medically uninsurable by assessing taxes and premiums on insurers, and other states are developing similar programs to provide broad-based access to health care to be financed by similar taxes or premiums. In addition, 22 states currently impose taxes on hospitals, doctors, and other providers to finance uncompensated health care.[12] Unless the Third Circuit's ruling is reviewed and reversed, even those states which have not yet attempted to reach the assets of self-funded plans, as have New Jersey, New York, and several other states, may be encouraged to do so on the grounds that such premiums are part of the costs of doing business in the state.

The NCCMP has vigorously opposed Congressional efforts to enact ERISA waivers for individual states because of its fundamental belief that "the health care crisis is a national problem that requires a uniform, federal solution, not fifty different conflicting solutions." [13] For the same reasons, the NCCMP even more vigorously opposes judicial efforts to carve out exemptions from preemption for such laws which threaten to perpetuate and increase the current crazy-quilt, state-by-state system of

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[12] 138 Cong. Rec. S13267-02, *S13268. The above information is contained in a "factsheet" supporting the proposed State Health Care Financing Equity Act.

[13] Letter from Robert A. Georgine to the Honorable Thomas S. Foley, dated May 21, 1993.

unfair cost-shifting that is jeopardizing multiemployer plans.

II. THE THIRD CIRCUIT'S DECISION IS INCONSISTENT WITH THIS COURT'S PREVIOUS DECISIONS AND CLOUDS THE CLEAR STANDARDS DEVELOPED BY THIS COURT.

Petitioners have clearly articulated the standards for preemption which this Court has enunciated in its prior decisions, and have shown how the Third Circuit has departed from those decisions, largely in reliance on an outdated decision of the Second Circuit, which even a New York court declined to follow in ruling that the surcharges imposed by New York's DRG statute are preempted by ERISA.[14] The NCCMP agrees with Petitioners' arguments, and will not repeat them here.[15]

However, the NCCMP would like to reiterate its concern that unless the Third Circuit's opinion is reviewed and reversed, federal courts will be encouraged both to depart from this Court's common sense, broad reading of § 514(a) and to carve out judicial exemptions from preemption for any one of the following reasons: the state law does not "purport to relate to" employee benefit plans; the state law is generally applicable and falls within traditional police powers; or the state law, despite its inordinate economic impact on employee benefit plans, has too remote or tenuous a connection with the plans to trigger preemption. Most importantly, the NCCMP is concerned that unless the Third Circuit's ruling is reviewed, the economic burdens imposed on plans by state laws will no longer figure in the ERISA preemption calculus on the grounds that such burdens are a mere cost of doing business in the state.

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[14] *Rebaldo v. Cuomo*, 749 F.2d 133 (2d Cir. 1984), *cert. denied*, 472 U.S. 1008 (1985); *Travelers Ins. Co. v. Cuomo*, 813 F. Supp. 996 (S.D.N.Y. 1993), appeal pending.

[15] The NCCMP also agrees with the district court's analysis in the case below, 793 F. Supp. 524 (D.N.J. 1992), as well as with Judge Nygaard's dissenting opinion on appeal, App. 32a-44a.

In the case at bar, the DRG statute clearly "relates to" employee benefit plans because: the statute was premised on the existence of ERISA plans as deep pockets; specifically referred to ERISA plans; operated through a cost-shifting mechanism designed to drain ERISA plans of assets for the purpose of funding benefits for nonparticipants, in violation of plan documents and trustees' fiduciary obligations to participants and beneficiaries; forced plans to restructure or eliminate benefits to accommodate the drain on plan assets; and increased the costs and burdens of plan administration. Moreover, DRG statutes, such as New Jersey's, could well cause plans to change their design by shifting from self-funded to insured status, if only to be able to benefit from the payor differentials afforded high volume insurers such as Blue Cross.

This Court has repeatedly pointed out that "ERISA preempts any state law that refers to or has a connection with covered benefit plans (and that does not fall within a § 514(b) exception) even if the law is not specifically designed to affect such plans, or the effect is only indirect." *District of Columbia v. Greater Washington Board of Trade*, 506 U.S. ——, 121 L.Ed.2d 513, 520 (1992) (citations omitted). Moreover, Congress clearly knows how to draft a § 514(b) exemption for state health care laws if it so desires, and did so for Hawaii's Prepaid Health Care Act. There is nothing in the structure of § 514 or in this Court's previous interpretations of ERISA's preemption provision to justify courts in carving out judicial exemptions from preemption merely because the state law may serve an important social goal.

In sum, the Third Circuit's ruling is inconsistent with this Court's previous precedents, casts a shadow on the standards enunciated by this Court, and threatens to cause great harm to self-funded multiemployer plans.

CONCLUSION

For the reasons stated above, the Court should grant the Petition for Certiorari and review the decision of the court below.

Respectfully submitted,

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